

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. HOUR	
BERNARD M. ACKERMAN		NOVEMBER 19, 1983		9:40P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. IF UNDER 1 YEAR	
MALE	WHITE	FEBRUARY 7, 1918	65	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		BALTIMORE COUNTY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
PIKESVILLE	MILFORD MANOR NURSING HOME		ACCOUNTANT		ACCOUNTING
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE		
MARYLAND	BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3307 NERAK RD. (21208)		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME				
LOUIS ACKERMAN	ANNIE FISHBEIN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
NO	216-01-5266	MRS. FLORENCE ACKERMAN 3307 NERAK RD. 21208			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> <u>1919</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>glaucoma of brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u> <u>months</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/18/83</u> to <u>11/19/83</u> , that (I) (we) lost saw the deceased alive on <u>11/3/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>11/21/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. BARBARA COCHRAN		22e. ADDRESS 6506 PARK HEIGHTS AVE.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 11/21/83		23c. NAME OF CEMETERY OR CREMATORY PROGRESSIVE RUDOMER VEREIN CEM.	
23d. LOCATION CITY OR TOWN COUNTY STATE		ROSEDALE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the funeral director. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>MARY M. ADDISON</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-20-83</i>		2b. HOUR M <i>9:50 PM</i>	
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10-29-1915</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>68</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ind.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co. MD.</i>		
10. CITY OR TOWN OF DEATH <i>Catonsville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Forest Haven Nursing Home</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Reg. Tacker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Tacking Co.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13c. STATE <i>Ind.</i>	13b. COUNTY <i>Baltimore</i>	13d. CITY OR TOWN <i>Baltimore</i>	13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13f. STREET ADDRESS <i>1250 Washington Blvd. 21230</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter Senkewic</i>	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maitha Petruska</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-24-6435</i>	17. INFORMANT <i>Donald T. Addison</i>		ADDRESS <i>2640 Garland Rd. 21230</i>		

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

2639 IMMEDIATE CAUSE (a) *Aspiration*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

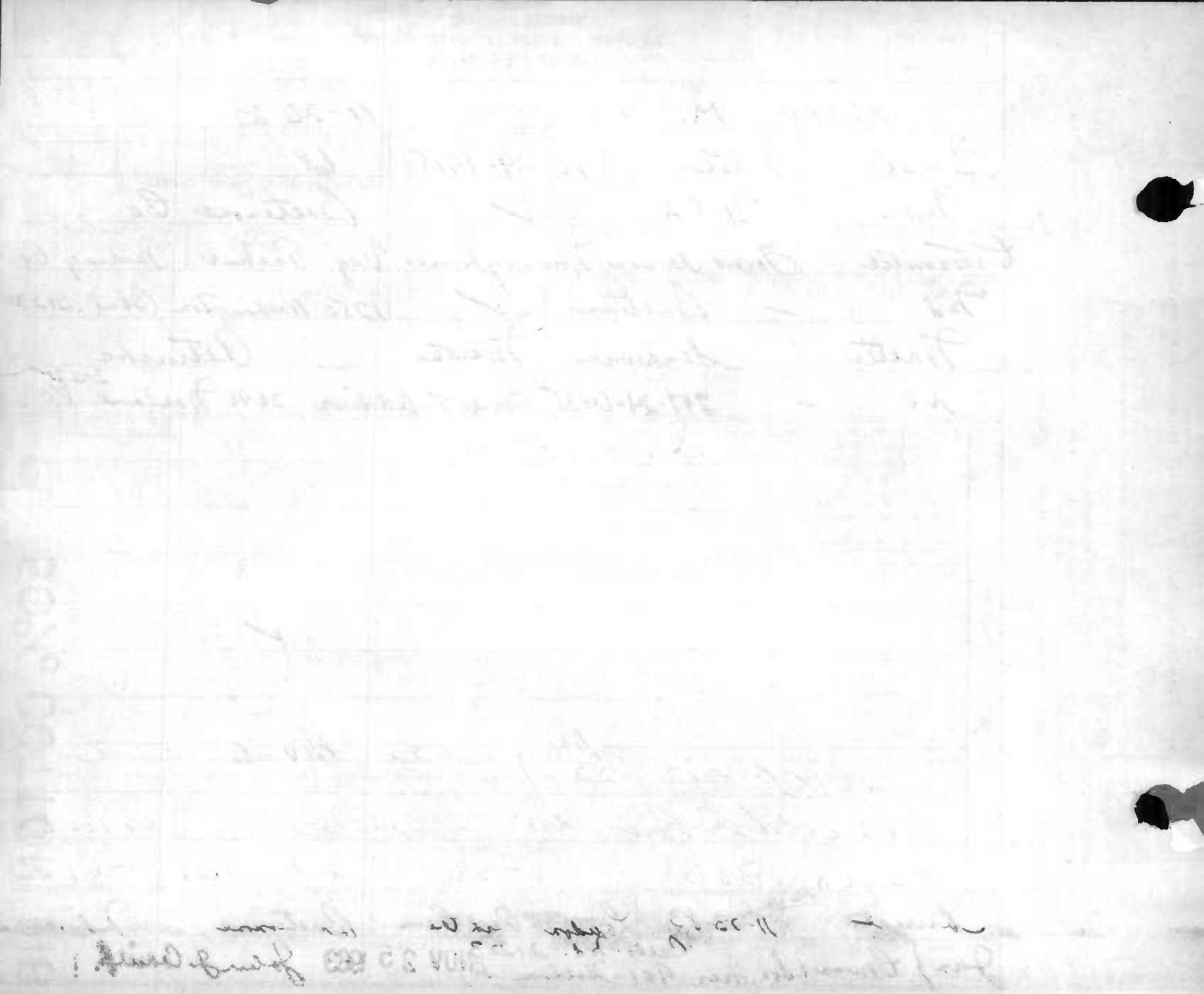
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> , 19 <i>83</i> , to <i>Nov 20</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Dec 17</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Harold Bob</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>Nov 22, 83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HAROLD BOB</i>		22e. ADDRESS <i>7220 Ark Heights 21208</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11-23-83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cem.</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Ind.</i>
24. FUNERAL DIRECTOR NAME <i>John J. Brown &amp; Son, Inc.</i>		ADDRESS <i>901 Hollins St.</i>	25a. DATE REC'D BY REGISTRAR <i>NOV 25 1983</i>
		25b. REGISTRAR'S SIGNATURE <i>John J. Brown</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 42 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST ROSE	MIDDLE MARIE	LAST AFTUNG	MONTH DAY YEAR 11 11 83			11:15 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 26 37	6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.					
10. CITY OR TOWN OF DEATH Woodlawn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7117 A. Rolling Bend Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Woodlawn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7117 A Rolling Bend Road		
14. FATHER'S NAME FIRST MIDDLE LAST Bernard J. Rykowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie E. Hergenhan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-34-9248		17. INFORMANT ADDRESS Richard I. Martel 7117 A Rolling Bend Rd.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 yrs</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/3</u> , 19 <u>81</u> , to <u>11/11</u> , 19 <u>83</u> , that (I/we) most saw the deceased alive on <u>11/10</u> , 19 <u>83</u> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.			
22b. SIGNATURE <u>William C. Waterfield</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>11/11/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William C. Waterfield</u>		22e. ADDRESS <u>St. Agnes Hospital</u> <u>900 Canton Ave. Balt Md 21229</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/14/83	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.	23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE NOV 14 1983	



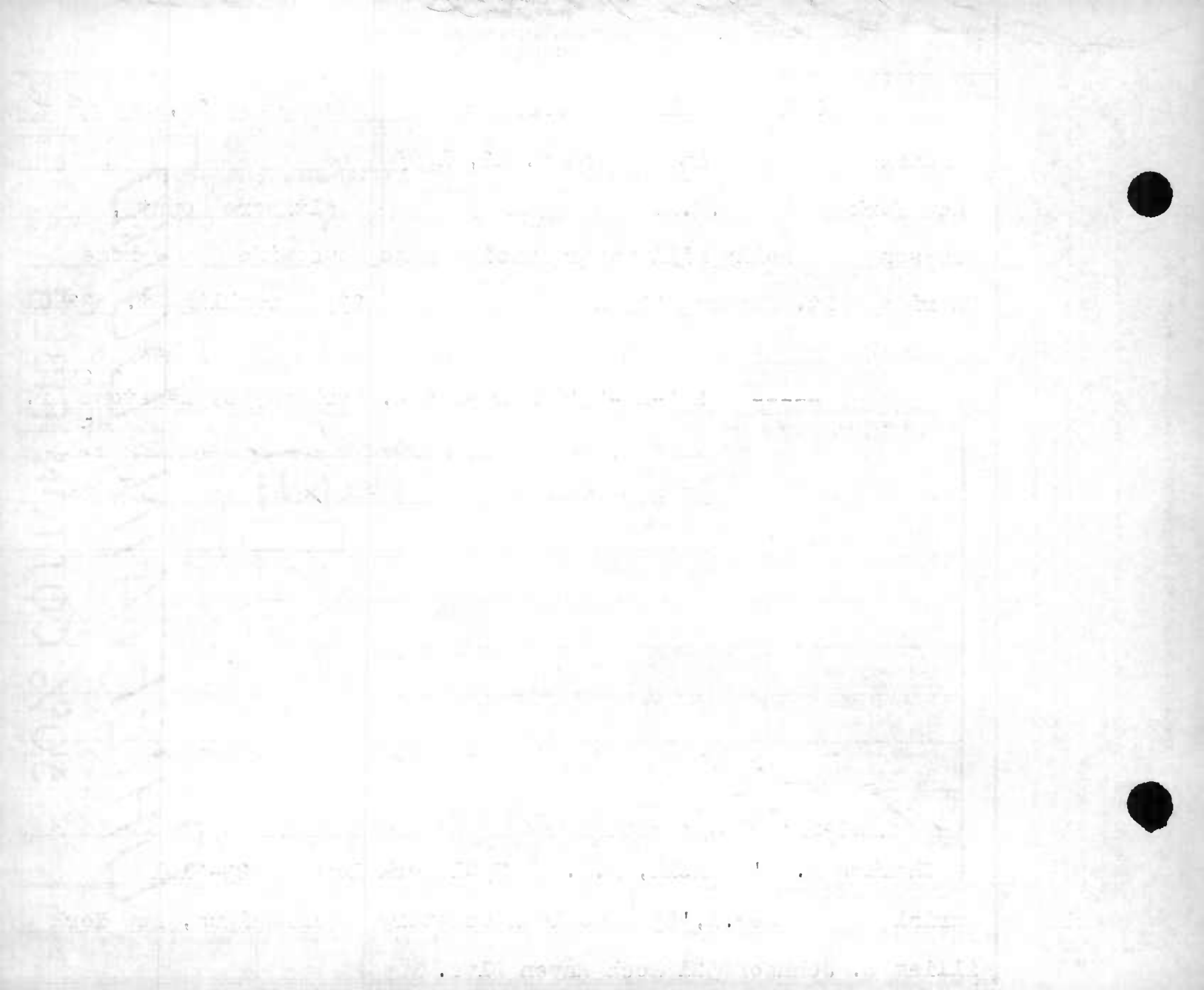
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28698			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>HELEN BATES ALLISON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 27, 1983</b> 2b. HOUR <b>12:55</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 12, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>	
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holly Hill Manor Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Florida</b>		13b. CITY OR TOWN <b>Ft. Meyers</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS <b>2350 Franklin St. 33901</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Bates</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen Brace</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>266-19-2524</b>		17. INFORMANT ADDRESS <b>Margaret A. Markham 21234 9409 Flagstone Dr.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>65 yrs.</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hrs.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>19 June 1971</b> to <b>27 November 1983</b> that (I) (we) last saw the deceased alive on <b>26 November 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles F. O'Donnell</b> DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/27/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles F. O'Donnell, M.D.</b>				22e. ADDRESS <b>7501 York Road 823-3161</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 1, '83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Canandaigua, New York</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>William E. Johnson 8521 Loch Raven Blvd.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					2 8 5 9 9					
1- FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) JOHN JOSEPH AMEND					2a. DATE OF DEATH MONTH DAY YEAR NOVEMBER 30, 1983				2b. HOUR 11 A. M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 19, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Armcast Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bar Tender		12b. KIND OF BUSINESS OR INDUSTRY Country Club		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Amend					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Fritz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-10-5990		17. INFORMANT Susan Hanley			ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>83</u> , to <u>11/30</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/15</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Frederick J. Vollmer M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/1/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick J. Vollmer, M.D.					22e. ADDRESS 6100 York Rd. Baltimore, Md. 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Dec. 1, 1983		23c. NAME OF CEMETERY OR CREMATORY Greenmount			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Md.		
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212					25. DATE REC'D BY REGISTRAR DEC 7 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Gandy</u>		

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†, 273

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 28700			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) <b>ANGELINA ANGELA E. AMORE</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>JAN. 27 1911</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 12 1983</b> 2b. HOUR <b>9<sup>28</sup> P M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RHODE ISLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTO. COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>CATONSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>105 S. HILLTOP PL.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>BALTO</b>		13c. CITY OR TOWN <b>CATONSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LUIGI SCUNGIO</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUCIA UNKNOWN</b>		13e. STREET ADDRESS <b>105 S. HILLTOP PL.</b>		13f. STREET ADDRESS <b>105 S. HILLTOP PLACE</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>036-18-8305</b>		17. INFORMANT <b>GIRO AMORE</b>		ADDRESS <b>105 S. HILLTOP PLACE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC BREAST CARCINOMA</b> 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED <input type="checkbox"/> WHILE WORKING <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
21g. I certify that (1) this hospital attended the deceased from <b>JUNE 25 1983</b> to <b>NOVEMBER 12 1983</b> and that (2) my (our) opinion of death occurred on the date and hour and from the causes stated above. (If we did not see the body after death)							
22a. SIGNATURE <b>DIANA H. GRIFFITHS</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/14/83</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO MD.</b>	
24. FUNERAL DIRECTOR NAME <b>WEBER FUNERAL HOME</b>		ADDRESS <b>EDMONDSON AV</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28701

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <del>XXXXXXXXXX</del> <i>Samuel Matthew Amoriello</i>			2a. DATE OF DEATH MONTH <i>11</i> DAY <i>23</i> YEAR <i>83</i> 5:12 <i>A</i> <i>11/23/1983</i> 5:12 <i>M</i>		
3. SEX <i>Male</i> <i>MALE</i>	4. RACE <i>White</i> <i>white</i>	5. DATE OF BIRTH MONTH <i>10</i> DAY <i>12</i> YEAR <i>1918</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> <i>xxs</i> YRS.		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>xx Pennsylvania</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co. County</i> MD.		
10. CITY OR TOWN OF DEATH <i>Towson</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY OR COUNTY, GIVE STREET ADDRESS) <i>Saint Joseph Hospital</i> <i>St. Joseph Hospital</i>		12a. USUAL OCCUPATION (TYPE WORK OR MOST OF WORKING LIFE) <i>Retired</i> <i>checker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Beth Steel</i> <i>Beth Steel</i>
13a. STATE <i>Md</i>	13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>400 Kane St.</i> <i>400 Kane St Baltimore City 21224</i>	
14. FATHER'S NAME FIRST <i>Pasquale</i> MIDDLE <i>Amoriello</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Mary</i> MIDDLE <i>Massario</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>218-05-9686</i>		17. INFORMANT ADDRESS <i>Carmella Amoriello 400 Kane Street 21224</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

4100  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10

*Anemia* *Poss. GI* *Sepsis*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) lost  
saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Gracia V. Patricia</i>	DEGREE	22c. DATE SIGNED <i>11/23/83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gracia V. Patricia</i>	22e. ADDRESS	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>11-26-83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Oak Lawn Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Eastwood, Balto Co., Md.</i>
24. FUNERAL DIRECTOR NAME <i>Charles S. Zeiler &amp; Son Inc.</i>		ADDRESS <i>6224 Eastern Ave.</i>	25. DATE RECD. BY REGISTRAR 25. REGISTRAR'S SIGNATURE <i>NOV 25 1983</i> <i>John J. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. THIS CERTIFICATE IS NOT VALID FOR BURIAL OR CREMATION UNTIL IT IS FILED IN THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		21. DATE OF DEATH		22. DATE OF DEATH		23. DATE OF DEATH		24. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS)		6. IF UNDER 1 YR.	
Janet Lee Anderson		F		W		3/16/43		40 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
MD.		USA		NEVER MARRIED		Baltimore County, MD.		Essex		825 Middle Road	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12c. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD.		HSE				MD.		BALTO		MIDDLE RIVER	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH	
UNK		UNK		NO		UNK		THOMAS ANDERSON		Gunshot wounds of chest and abdomen (handgun)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		? P.M. 11 3 1983		Subject shot	
22a. I certify that I took charge of the remains described above, held on		22b. TIME OF INJURY		22c. HOW INJURY OCCURRED		23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		house		825 Middle Rd.		CREMATION		11/7/83		SECURITY PROCESS	
death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		26a. DATE REC'D. BY REGISTRAR		26b. REGISTRAR'S SIGNATURE	
Margarita A. Korell, M.D.		300 Mace ave.		NOV 14 1983		John J. Carver					



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Lillian B. Armetta</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 18, 1983</b>		2b. HOUR M <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 23, 1925</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>58</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rosedale</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>46 Talister Court</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife &amp; Mother</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Rosedale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>46 Talister Ct 21237</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Walters</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Blades</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-16-6847</b>		17. INFORMANT ADDRESS <b>Mr Michael Armetta Same As 13e</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4149

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>80</b> , to <b>11-18</b> , 19 <b>83</b> that (I) <del>(was)</del> last saw the deceased alive on <b>10-17</b> , 19 <b>83</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(would)</del> did not view the body after death.			
22b. SIGNATURE <b>Marion C. Kowalewski</b>	DEGREE <b>M.D.</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>11-18-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Marion C Kowalewski M.D.</b>		22e. ADDRESS <b>8604 Harford Rd Baltimore, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov 21 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Leonard J Ruck Inc, Baltimore, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Jan. 23, 1933

Yonkers & Poughkeepsie

Jan. 23, 1933



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner requires notification of police.

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28704			
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE D. ARNOLD</b>				7a. DATE OF DEATH MONTH DAY YEAR <b>November 22, 1983</b>				7b. HOUR <b>11:55 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 72 HRS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Pikesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4108 Colby Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreman - Diamond International</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Pikesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>4108 Colby Road 21208</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Arnold, Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia T. Weatherstein</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>212-09-9673</b>				17. INFORMANT ADDRESS <b>Mrs. Genevieve S. Arnold 4108 Colby Road 21208</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few hrs.</b> <b>2-4 hrs.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Old MI; L.V. Aneurysm Complete RBBB</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11-22-83</b> to <b>11-23-83</b> , that (I) (we) last saw the deceased alive on <b>11-22-83</b> at <b>19:53</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E.C. Galvez</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edito C. Galvez, M.D.</b>				22e. ADDRESS <b>5400 Old Court Road</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11-26-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>				ADDRESS <b>1050 York Road</b>		75a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		75b. REGISTRAR'S SIGNATURE <i>John J. White</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

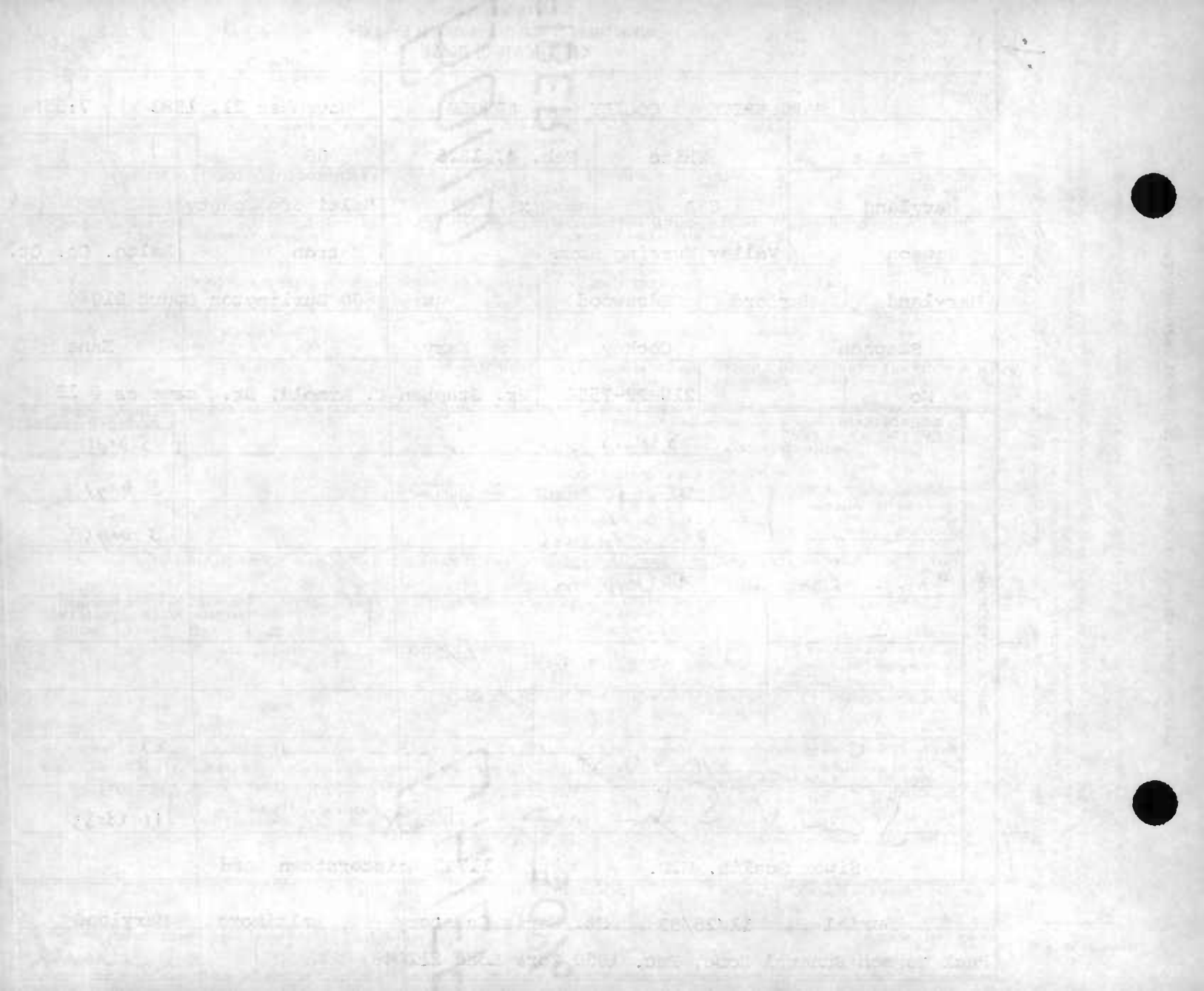
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
MARGUERITE COCKEY ARNOLD						November 21, 1983						7:55PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Feb. 4, 1895		88 YRS.		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Baltimore County MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Towson		Valley Nursing Home		Matron		Balto. Co. Ct.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Harford		Edgewood		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		600 Burlington Court 21040					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Stephen Cockey				Mary Kane									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No				218-32-7556		Mr. Stephen C. Arnold, Sr. same as # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) SEPSIS												3 Days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF													
(b) urinary tract infection												5 Days	
DUE TO, OR AS A CONSEQUENCE OF													
(c) renal failure												5 Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
Atrial Fibrillation Dehydration													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10-11, 1983, to 11, 1983, that (I) (we) last saw the deceased alive on 11-4-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE								DEGREE		22c. DATE SIGNED			
Simon Scalia, M.D.								M.D.		11-23-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS					
Simon Scalia, M.D.								11722 Reisterstown Road					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				11/25/83		Mt. Maria Cemetery				Baltimore Maryland			
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR					
NAME Ruck Towson Funeral Home, Inc. 1050 York Road 21204								25b. REGISTRAR'S SIGNATURE					
								NOV 25 1983					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		Nov. 22 1983		11 32 P.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB. 4, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ARKANSAS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore COUNTY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Maryland State Hospital 509 E. Tupper Rd. Balt 21204		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD MARR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EALNORA KITCHEN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO 497-09-2040D 338-16-1395		17. INFORMANT ROBERT E. MARR		ADDRESS PALM HARBOR, FLA. 1692 CITRUS HILL LA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anaplastic carcinoma of pelvis (primary site not certain) DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypercalcemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/83 19, to 11/22 1983, that (1) (we) lost saw the deceased alive on 11/17 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard J. Gross M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard J. Gross M.D.		22e. ADDRESS 50 Scott Day Rd, Cockeysville, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE NOV. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME MITCHELL-WIEDEFELD HOME		ADDRESS 6500 YORK RD. 21212		25a. DATE REC'D. BY REGISTRAR NOV 28 1983		25b. REGISTRAR'S SIGNATURE John J. Grieb	





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Donald Edward Barnard								11/28/83										M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Male		White		Dec. 23 1945		37 YRS.				11/28/83								1:11 A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore, Md.		USA						Baltimore County										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS													
Rossville 21237		Franklin Square Hospital		Carpenter		Improvements													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md.		Baltimore		Essex 21221		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		53 Seversky Court 21221											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
George Barnard		Edna Schwiakart																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		212 42 6657		Robert Jennings, Brother Balto., Md.		41 Dogwood Dr.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4292		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		11/28/83													
Margarita A. Korell, M.D.		M.D. Assistant																	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
Margarita A. Korell, M.D.		111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (IFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		12/1/83		Holly Hill Memorial Gardens		Baltimore Co., Md.													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
Funeral Home		NOV 29 1983		John J. Cariff															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME FOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

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Nov 2 1963  
J. J. J. J. J.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST <b>RUFFIN BARNES</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 15 1983</b>		2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 18 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Johnston Co N.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>48 S. Kossuth Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Steel Bethlehem</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>48 S. Kossuth St. Md. 21229</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thaxton Barnes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hattie Shoul</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>238-28-8481</b>		17. INFORMANT <b>Amanda Barnes</b>		ADDRESS <b>48 S. Kossuth Street Baltimore, Md. 21229</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive CVA, Probable</b> <b>4019</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Asthma</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>P. O. Bennett</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P. O. BENNETT</b>				22e. ADDRESS <b>2231 GARRISON, 2A BALTO. MD. 722-9470</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/19/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Star Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>			
24. FUNERAL DIRECTOR'S NAME <b>NOTTER &amp; SONS</b>		24b. ADDRESS <b>2501 Gwynns Falls Pkwy. Baltimore, Md. 21216</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Warren <del>BARTH</del> C.J. Barth</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 6, 1983</b>		2b. HOUR <b>5:06 P</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 31 1914</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore county</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rossville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Sq. Hos.</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Inspector, Claim</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>White Marsh</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5200 Bangert Street 21162</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Barth</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anastacia Houston</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>216-05-6147</b>	17. INFORMANT ADDRESS <b>5200 Bangert St.</b> <b>Mrs. Ruth Barth, White Marsh, Md. 21162</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabete mellitus</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 6 1983</b> , to <b>NOV 6 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov 6 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <i>Micheal Heller</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>NOV 6 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Micheal Heller M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-10-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cath. Ch. Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pylesville Harford Md.</b>
24. FUNERAL DIRECTOR NAME <b>E. F. Lassahn</b>		ADDRESS <b>11750 Belair Rd. Kingsville, Md. 21088</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>	
		25b. REGISTRAR'S SIGNATURE <i>John J. Casper</i>			

BP



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CHIEF

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME

FIRST

MIDDLE

LAST

MARY

Belle

BASTFIELD

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

11-30-83

30 83

4:10 PM

3. SEX

FEMALE

4. RACE

NEGRO.

5. DATE OF BIRTH

MONTH

DAY

YEAR

2 19 06

6. AGE (IN YEARS LAST BIRTHDAY)

77

YRS

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

S. Carolina

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County, MD.

10. CITY OR TOWN OF DEATH

Randallstown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
BALTIMORE CO. GENERAL HOSPITAL

12a. USUAL OCCUPATION

(TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

Maryland

13b. COUNTY

Baltimore

13c. CITY OR TOWN

Baltimore

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

3033 Spaulding Ave. 21215

14. FATHER'S NAME

James

MIDDLE

E.

LAST

Smith

15. MOTHER'S MAIDEN NAME

Georgianna

MIDDLE

Foster

LAST

Foster

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)  
NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

212-14-1510

17. DECEASED AT

James Bastfield 5314 Midwood Avenue

Lloyd Bastfield 3033 Spaulding Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5990

RECURRENT CEREBRO-VASCULAR ACCIDENT

DUE TO, OR AS A CONSEQUENCE OF

(b)

DIABETES MELLITUS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

URINARY TRACT INFECTION.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ AT WORKNOT WHILE ☐ AT WORK

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 11-27-1983 to 11-30-1983, that (I) (we) lost

saw the deceased alive on 11-30-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING

PHYSICIAN ☐

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☒

22c. DATE SIGNED

11-30-83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

DR. SUDHIR D. PATEL

22e. ADDRESS

BAL. COUNTY GEN. HOSPITAL

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

BURIAL

23b. DATE

12/6/83

23c. NAME OF CEMETERY OR CREMATORY

Md. National Mem Pk. Laurel,

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

Md.

24. FUNERAL DIRECTOR

NAME

Wm C March F/H Inc, 1101 E North Avenue

25a. DATE REC'D. BY REGISTRAR

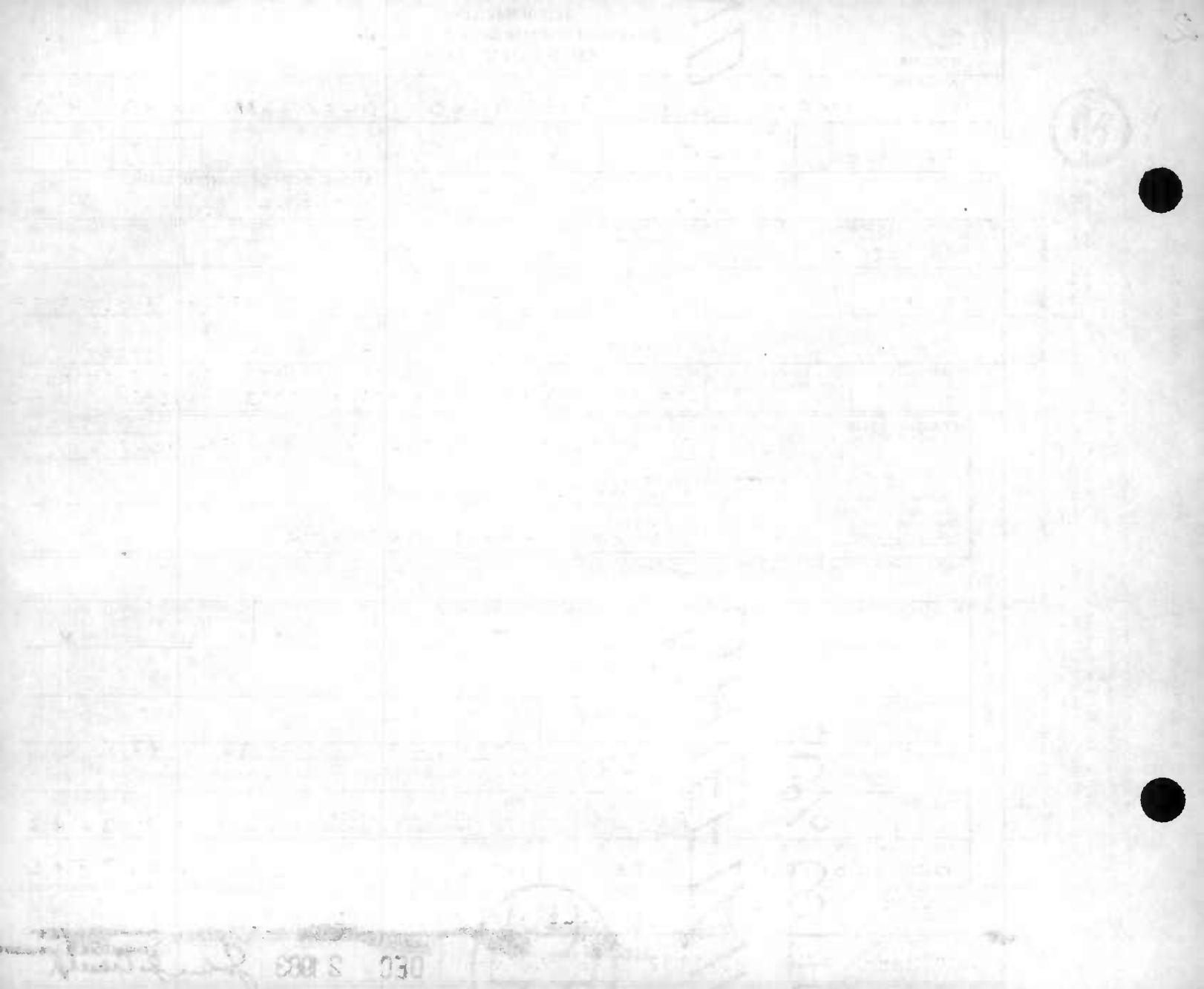
DEC 2 1983

25b. REGISTRAR'S SIGNATURE

John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 must be retained by the hospital or attending physician.

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DEC 8 1963



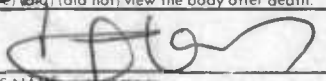

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BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				28711			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Wallis Beatty				2a. DATE OF DEATH MONTH DAY YEAR November 20, 1983			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 7, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD	
10 CITY OR TOWN OF DEATH Parkville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2321 Salem Village Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Brass Molder Mechanic-Lacey Co.		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Parkville		13e. STREET ADDRESS / ZIP CODE 2321 Salem Village Road 21234	
14 FATHER'S NAME FIRST MIDDLE LAST Harry J. Beatty				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Serena Wallis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-7224A		17. INFORMANT ADDRESS Mrs Mary E. Beatty, Same As #13e 21234			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest</u> 4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardiac arrhythmia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 79, to 2-2 19 83, that (I) (we) last saw the deceased alive on 2-2 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE 				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Venancio Alidio M.D.				22e. ADDRESS 6010 York Road, Baltimore, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11-22-83		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204				25a. DATE REC'D. BY REGISTRAR NOV 22 1983			
				25b. REGISTRAR'S SIGNATURE 			

MEDICAL CERTIFICATION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

2 8 / 1 2

3  
1- FOR  
STATE  
REGISTRAR

REG. NO.

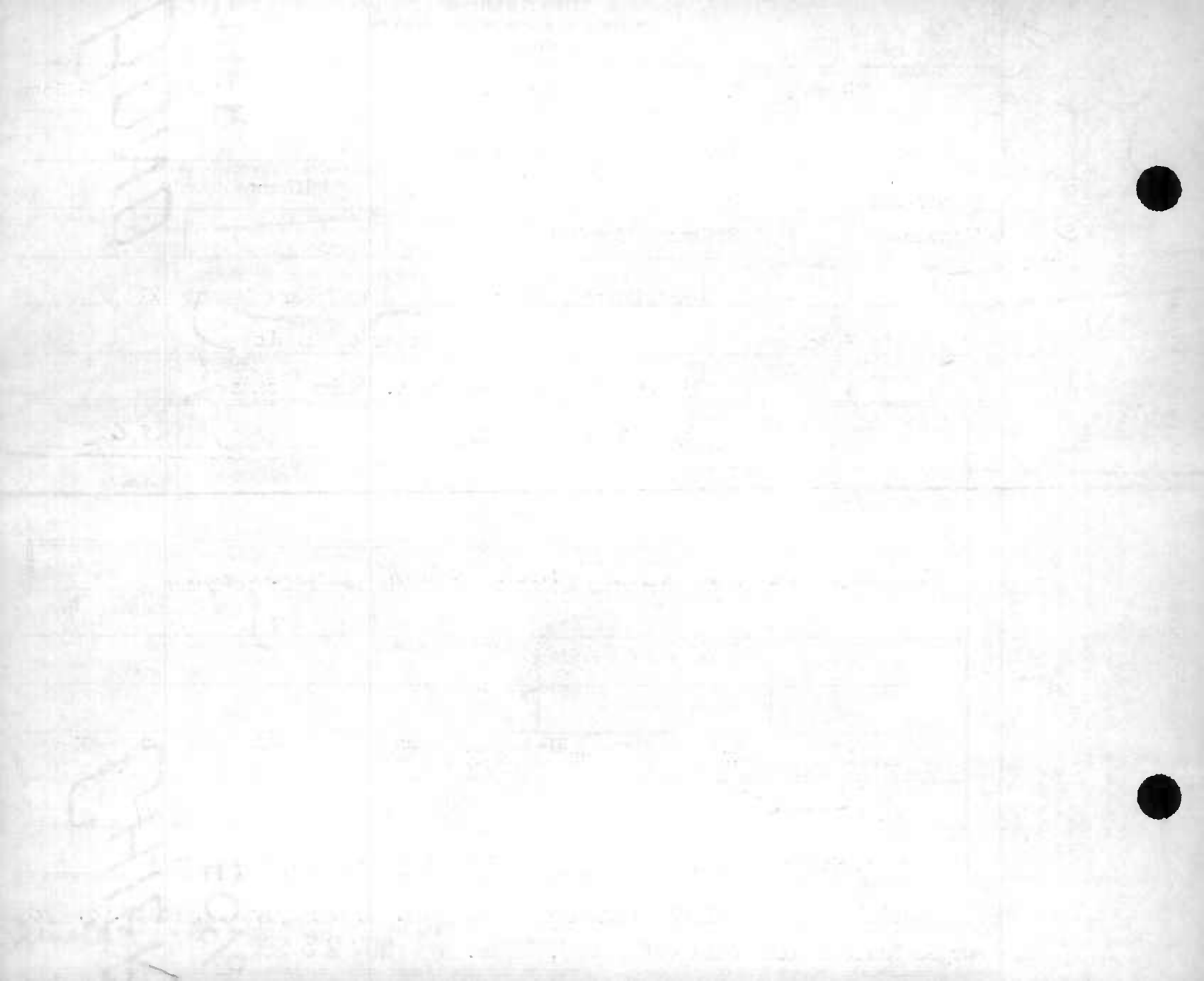
1. DECEASED NAME (TYPE OR PRINT) Hilda T. Beebe			2a. DATE OF DEATH MONTH DAY YEAR 11-15-83		2b. HOUR 3:45pm
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 5, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore county MD.	
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL, GIVE ADDRESS) St Joseph Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker		12b. KIND OF BUSINESS OR INDUSTRY Bakery
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md			13b. COUNTY -	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Lavina Briza			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Rabbit		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 09 6228		17. INFORMANT ADDRESS Clarence L. Beebe same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 5570 IMMEDIATE CAUSE (a) <i>Mesenteric infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Advanced atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days syncope					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>Peripheral vascular disease, chronic obstructive pulmonary disease</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>11-6</u> , 19 <u>83</u> , to <u>11-15</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>11-15</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Habersat, M.D.		22e. ADDRESS 7620 York Road towson Md 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/18/83	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Pk Cockeysville, Balto. Co. Md		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Burgee Funeral Home 3631 Falls Road, Balto. Md		25a. DATE REC'D. BY REGISTRAR 21211 NOV 23 1983		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled in by the funeral director. Pages 5 and 6 should be filled in by the funeral director. Pages 7 and 8 should be filled in by the funeral director. Pages 9 and 10 should be filled in by the funeral director. Pages 11 and 12 should be filled in by the funeral director. Pages 13 and 14 should be filled in by the funeral director. Pages 15 and 16 should be filled in by the funeral director. Pages 17 and 18 should be filled in by the funeral director. Pages 19 and 20 should be filled in by the funeral director. Pages 21 and 22 should be filled in by the funeral director. Pages 23 and 24 should be filled in by the funeral director. Pages 25 and 26 should be filled in by the funeral director. Pages 27 and 28 should be filled in by the funeral director. Pages 29 and 30 should be filled in by the funeral director. Pages 31 and 32 should be filled in by the funeral director. Pages 33 and 34 should be filled in by the funeral director. Pages 35 and 36 should be filled in by the funeral director. Pages 37 and 38 should be filled in by the funeral director. Pages 39 and 40 should be filled in by the funeral director. Pages 41 and 42 should be filled in by the funeral director. Pages 43 and 44 should be filled in by the funeral director. Pages 45 and 46 should be filled in by the funeral director. Pages 47 and 48 should be filled in by the funeral director. Pages 49 and 50 should be filled in by the funeral director. Pages 51 and 52 should be filled in by the funeral director. Pages 53 and 54 should be filled in by the funeral director. Pages 55 and 56 should be filled in by the funeral director. Pages 57 and 58 should be filled in by the funeral director. Pages 59 and 60 should be filled in by the funeral director. Pages 61 and 62 should be filled in by the funeral director. Pages 63 and 64 should be filled in by the funeral director. Pages 65 and 66 should be filled in by the funeral director. Pages 67 and 68 should be filled in by the funeral director. Pages 69 and 70 should be filled in by the funeral director. Pages 71 and 72 should be filled in by the funeral director. Pages 73 and 74 should be filled in by the funeral director. Pages 75 and 76 should be filled in by the funeral director. Pages 77 and 78 should be filled in by the funeral director. Pages 79 and 80 should be filled in by the funeral director. Pages 81 and 82 should be filled in by the funeral director. Pages 83 and 84 should be filled in by the funeral director. Pages 85 and 86 should be filled in by the funeral director. Pages 87 and 88 should be filled in by the funeral director. Pages 89 and 90 should be filled in by the funeral director. Pages 91 and 92 should be filled in by the funeral director. Pages 93 and 94 should be filled in by the funeral director. Pages 95 and 96 should be filled in by the funeral director. Pages 97 and 98 should be filled in by the funeral director. Pages 99 and 100 should be filled in by the funeral director.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Alma Hanna Berkenkemper</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 8 1983</b>			2b. HOUR M				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 4 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Pikesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Milford Mill Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Rockdale</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>8310 Liberty Road 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Seiler</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Johanna M. Koblitz</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-34-2223</b>		17. INTERMENT ADDRESS <b>Ernest Seiler 21207 8310 Liberty Road Baltimore Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Paranoma of the Pancreas</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/11/83</b> to <b>11/8/83</b> , that (I) (we) lost saw the deceased alive on <b>11/8/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Robert Kroon</b>			DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/9/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert Kroon</b>			22e. ADDRESS <b>8726 Rte 100</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-10-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b> ADDRESS <b>8728 Liberty Road Randallstown, Maryland 21133</b>					25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

MEDICAL CERTIFICATION



1911

January 1 1911

January 1 1911

January 1 1911

John J. Sullivan  
John J. Sullivan

John J. Sullivan  
John J. Sullivan

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John J. Sullivan

John J. Sullivan

1911

John J. Sullivan

John J. Sullivan

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM BIALOZYNSKI (WHITE)</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-9-1983</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2-7-1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>ROSEDALE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FRANKLIN SQUARE HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS <b>510 CRISFIELD RD 21220</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN			
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS BIALOZYNSKI</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANTOINETTE HOFFMAN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WWH 218 018800</b>		17. INFORMANT ADDRESS <b>ROSE BIALOZYNSKI 510 CRISFIELD RD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO SCLEROTIC CARDIOVASCULAR Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-27</b> , 19 <b>83</b> , to <b>11-9</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>10-27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Larry G. Silley</b> MD				22c. DATE SIGNED <b>11-10-83</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LARRY G. SILLEY</b>	
22e. ADDRESS <b>1812 W D North Point Rd BALTIMORE, MD 21224</b>							
23a. BURIAL, CREMATION, REMOVAL (IF)		23b. DATE <b>11-12-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. STANISLAUS CEM</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>	
24. FUNERAL DIRECTOR NAME <b>RAYMOND L. KACZOROWSKI</b> ADDRESS <b>2525 FLEET ST.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

BP



20% COTTON FIBRE

CHIEF 14MM

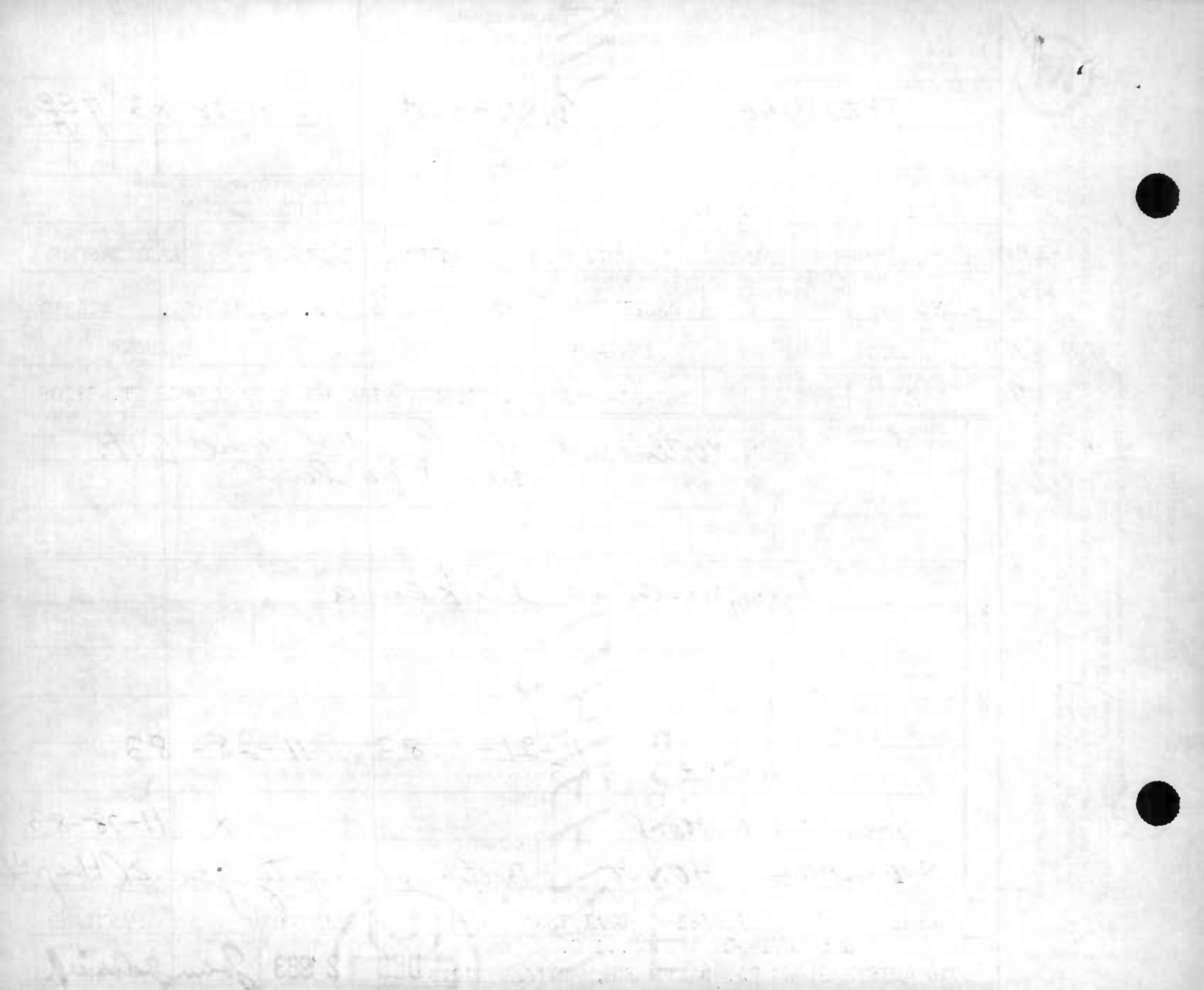


MADE IN INDIA

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>THEODORE</b>		FIRST <b>BIRNBACH</b>		LAST		2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-83</b>		2b. HOUR <b>7:50</b> M	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 9, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>MD.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>RANDALLSTOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>LADIES SHOP</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3203 N. CHARLES ST. #21218</b>			
14. FATHER'S NAME FIRST <b>JACOB</b> MIDDLE <b>BIRNBACH</b> LAST <b>SARAH</b>		15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>232-54-3443</b>		17. INFORMANT ADDRESS <b>MR. GILBERT BIRNBACH 3 FARMHOUSE CT. 21208</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/13</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Lymphocytic leukemia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11-21-1983</b> to <b>11-28-1983</b> , that (I) (we) lost saw the deceased alive on <b>11-28-83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Soonchal Hong</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>11-28-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SODNCHUL HONG</b>		22e. ADDRESS <b>Baltimore County General Hospital</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>11/29/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BNAI ISRAEL CEM</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <b>SOL LEVINSON &amp; BROS., INC.</b> ADDRESS <b>6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215</b>						25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 28716

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth E. Blackmon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 12, 1983</b>		2b. HOUR <b>7:30p.m.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 27 1910</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>South Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rossville 21237</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Franklin Sq. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>Middle River</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>16 Gyro Drive 21220</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Taylor</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Elizabeth Daniels</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>256 20 9084</b>	17. INFORMANT ADDRESS <b>Barbara Morlock 721 Clover Ave. Balto 21221</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atrial Tachyarrhythmia and Cardiac Ischemia, Complicating Recovery From Cholecystitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Cardiac Disease, Cardiomegaly</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Pancytopenia</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 27 1983</b> to <b>November 12 1983</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>November 12 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <b>Gary A. Walford</b> M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gary Walford, M.D.</b>				22e. ADDRESS <b>9000 Franklin Square Drive, 21237</b>	

23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>11/15/83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Holly Hill Memorial Gardens</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., Md.</b>
24. FUNERAL DIRECTOR <b>St. Elizabeth's Funeral Home PA 1407 Old Eastern Ave</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>

20% COTTON

CHIEFMAN



28/10/11

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CATHERINE</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>14</b> YEAR <b>83</b>			2b. HOUR <b>6:16A</b>			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>12</b> DAY <b>8</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS. <b>87</b>		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		8b. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>DUNDALK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN NURSING CTR. - HERITAGE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>BALTIMORE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>512 S. KENWOOD AVE.</b>	
14. FATHER'S NAME FIRST <b>JOSEPH</b> MIDDLE <b>POPROCH</b> LAST <b>POPROCH</b>				15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
17. SOCIAL SECURITY NO. <b>NO</b>				18. INFORMANT <b>EDWARD BLAZUCKI</b>				19. ADDRESS <b>2121 EASTERN AVE.</b>	
18. CAUSE OF DEATH Enter only one cause per item (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure acute</b> DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Hypertensive Cardiovascular</b> DUE TO, OR AS A CONSEQUENCE OF, (c) <b>Disease CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/11/83</b> to <b>11/14/83</b> , that (I) (we) last saw the deceased alive on <b>11/11/83</b> above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Theo C Patterson</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11-14-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. THEODORE PATTERSON-</b>						22e. ADDRESS <b>3427 DUNDALK AVENUE</b>			
23a. BURIAL, CREMATION, REMOVAL (CHECK) <b>BURIAL</b>			23b. DATE <b>11/17/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy ROSARY Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Raymond L. Kaczorowski</b> ADDRESS <b>2525 FLEET ST.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

U. D. 500



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Two C. F. Foster



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

BP

FOR  
1- STATE  
REGISTRAR **STEPHEN F. BLAZUCKI**

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Stephen F. Blazucki</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-5-83</b>		2b. HOUR <b>4:45AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 13 16</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>66</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>66</b>		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County MD.</b>		
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Towson</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Stella Mario Hospice</b>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PREST</b>		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <b>Md.</b>		15b. COUNTY <b>Baltimore</b>		15c. CITY OR TOWN <b>Baltimore</b>		
16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16a. STREET ADDRESS <b>4708 Prudence St. (21226)</b>		16b. STREET ADDRESS <b>4708 Prudence St. (21226)</b>		
17. FATHER'S NAME FIRST MIDDLE LAST <b>FELIX S. Blazucki</b>		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE B. Poproch</b>		17. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE B. Poproch</b>		
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		18b. SOCIAL SECURITY NO. <b>216-14-7679</b>		17. INFORMANT ADDRESS <b>Edward M. Blazucki 2121 Eastern Ave. 21231</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes Mellitis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>June 20</b> , 19 <b>78</b> , to <b>November 5</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 4</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Eddie Nakhuda</b>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <b>11/5/83</b>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eddie Nakhuda</b>		22f. ADDRESS <b>Stella Mario Hospice</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rosary Cemetery</b>		
23d. LOCATION CITY OR TOWN <b>Baltimore</b>		23e. COUNTY <b>Baltimore</b>		23f. STATE <b>Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Balto., Md. 21225</b>		24b. ADDRESS <b>George J. Gonce F.H. 4001 Ritchie Hwy.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 7 1983</b>		
25b. REGISTRAR'S SIGNATURE <b>John J. Gonce</b>		25c. REGISTRAR'S SIGNATURE <b>John J. Gonce</b>				

STATIONER, BARNETT

CHILDS



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28 / 19

1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Louis Joseph Boeh, Sr.</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>November 17, 1983</i>			
3. SEX <i>Male</i>				4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Dec. 11, 1908</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>74</i> YRS.	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>3610 Lilac Avenue</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>				13b. COUNTY <i>Baltimore</i>		13c. STREET ADDRESS <i>3610 Lilac Avenue, 21227</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Joseph Boeh</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Theresa Zinkand</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>220-44-5847</i>		17. INFORMANT ADDRESS <i>Louis J. Boeh, Jr. Same as #13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory Arrest</i> 1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Metastatic Laryngeal Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/10</i> to <i>11/10</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/10</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death, so state.)							
22b. SIGNATURE <i>W. Clark Gray</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/18/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. William Clark Gray, M.D.</i>				22e. ADDRESS <i>University of Maryland Hospital</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>No Burial</i>		23b. DATE <i>11/21/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Mem. Pk.,</i>		23d. LOCATION CITY OR TOWN COUNTY <i>Glen Burnie, A. A. Co., Md.</i>	
24. FUNERAL DIRECTOR NAME <i>McCurly Funeral Homes</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 22 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

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1902, 1903, 1904, 1905, 1906, 1907, 1908, 1909, 1910, 1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 25

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28 / 20

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary M. Boldon</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 25, 1983</b>		2b. HOUR <b>6:45am</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6 20 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rosedale</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>State</b>

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Cockeysville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>14 St. Elmo Court</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>John McKinnon</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>294-07-1555</b>		17. INFORMANT <b>Nancy Roberts</b>		ADDRESS <b>14 St. Elmo Court Cockeysville, Md.</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, Aspiration</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5070 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <b>Cardiac Disease-Right Bundle Branch Block</b>	
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 25, 1983</b> to <b>November 2, 1983</b> , that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>November 25, 1983</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do) view the body after death.			
22b. SIGNATURE <b>James P. de la Flor, MD</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>11/25/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James de la Flor, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Drive 21237</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-29-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Protestant Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Chardon Township, Geauga, Ohio</b>
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24. FUNERAL DIRECTOR NAME ADDRESS <b>Marzullo Funeral Service Reisterstown, Md.</b>	25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. DECEASED NAME		2a. DATE OF DEATH		2b. HOUR	
FIRST	LAST	MONTH	DAY	YEAR	
ROSE	BONAVITACOLA	11	21	83	6:00A.M.
3. SEX		4. RACE		5. DATE OF BIRTH	
FEMALE		CAUCASIAN		MONTH DAY YEAR	
6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7a. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
U.S.A. PA. PHILA.		U.S.A.		BALTIMORE CITY OR COUNTY OF DEATH	
9. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
TOWSON		MULTI MEDICAL NSG + CONV CENTER		HOUSEWIFE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
MD		BALTIMORE		TIMONIUM	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
STEPHEN DEL BUONO		MARY GIANTONIO		203-26-7928	
17. INFORMANT		18. ADDRESS		19. DATE OF OPERATION	
ROSEMARY HEDLEY		32 HATHAWAY RD, TIMONIUM, MD.		19a. DATE OF OPERATION	
20. CAUSE OF DEATH		21. OTHER SIGNIFICANT CONDITIONS		22. DATE SIGNED	
PART I. DEATH WAS CAUSED BY:		CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a		11/21/83	
IMMEDIATE CAUSE (a) Sepsis					
4360					
DUE TO, OR AS A CONSEQUENCE OF:					
(b) Decubitus Ulcers					
DUE TO, OR AS A CONSEQUENCE OF:					
(c) CVA					
23. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		11/23/83		HOLY CROSS	
24. FUNERAL DIRECTOR		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Richard Goode		NOV 28 1983		John J. Conish	



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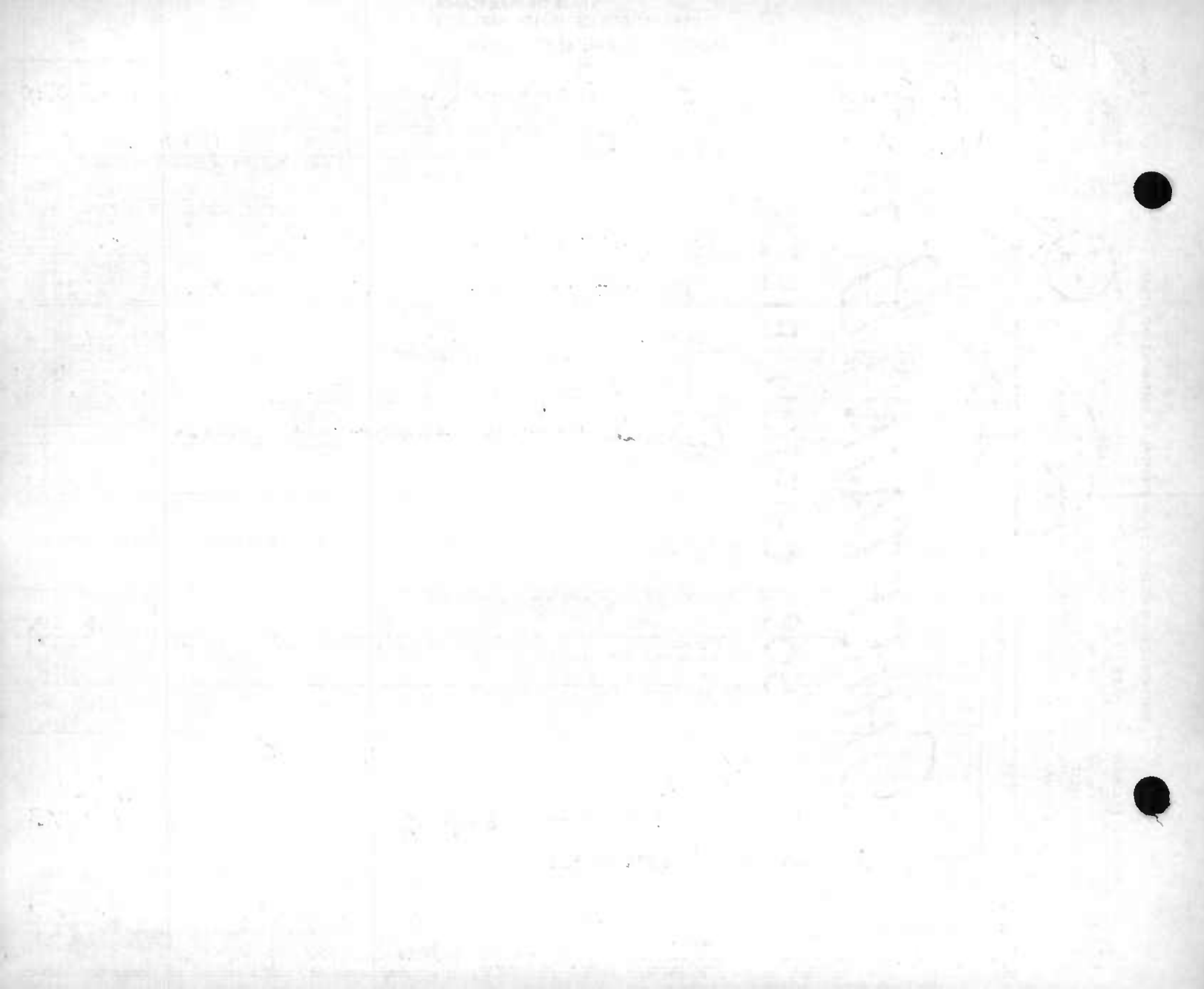
10 32 10 00A

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. (REVIEW PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 7 2 2 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Alfred B. Borowsky</b>										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>11 17 1983</b>				2b. HOUR <b>0740</b>									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 17 28</b>		6. AGE IN YEARS LAST BIRTHDAY <b>55 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN <b>55 YRS.</b>		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>11-17-13</b>		2d. HOUR <b>1:22 A M</b>											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.											
10. CITY OR TOWN OF DEATH <b>Sparrows Point</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sparrows Point Dispensary</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>											
13a. STATE <b>Maryland</b>				13b. COUNTY <b>131</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6622 Marne Avenue 21224</b>													
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benjamin Borowsky</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Clutzick</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>Korea 213-26-9003</b>											
17. INFORMANT <b>Kay F. Borowsky</b>				ADDRESS <b>6622 Marne Ave. Balto., MD. 21224</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>Chronic ischemic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>11/17/83</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>				ADDRESS																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>11/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakewiew Memorial</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sykesville Maryland</b>													
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>				ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Lander</b>											

BP



Item 10b, Film #G585 -

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR 11/22/83jlb  
1. STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Helen F. Bosies</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 16, 1983</i>			2b. HOUR <i>11:13 PM</i>		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 8, 1923</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>60</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County, MD</i>		
10. CITY OR TOWN OF DEATH <i>Catonsville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCLUDE FACILITY'S STREET ADDRESS) <i>654 Coleraine Road</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY -----

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Baltimore</i> 13c. CITY OR TOWN <i>Catonsville</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>654 Coleraine Rd. 21228</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>James J. Butler</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Kathryn Kelly</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b. <i>214-14-8832</i> INFORMANT <i>Catonsville, Md. 21228</i> <i>212-14-8832</i> <i>Melvin J. Bosies-654 Coleraine Rd.</i> <i>Husband</i>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CNS Coma</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Brain Metastases</i> (c) <i>Key Coma</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>1 mo.</i> <i>2 1/2 mo.</i>	
--	--	---	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>11/8</i> 19 <i>82</i> to <i>11/17</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/8</i> 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William C. Waterfield</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>11/17/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William C. Waterfield M.D.</i>				22e. ADDRESS <i>St. Agnes Hospital</i> <i>900 Caton Ave Balt Md 21229</i>			

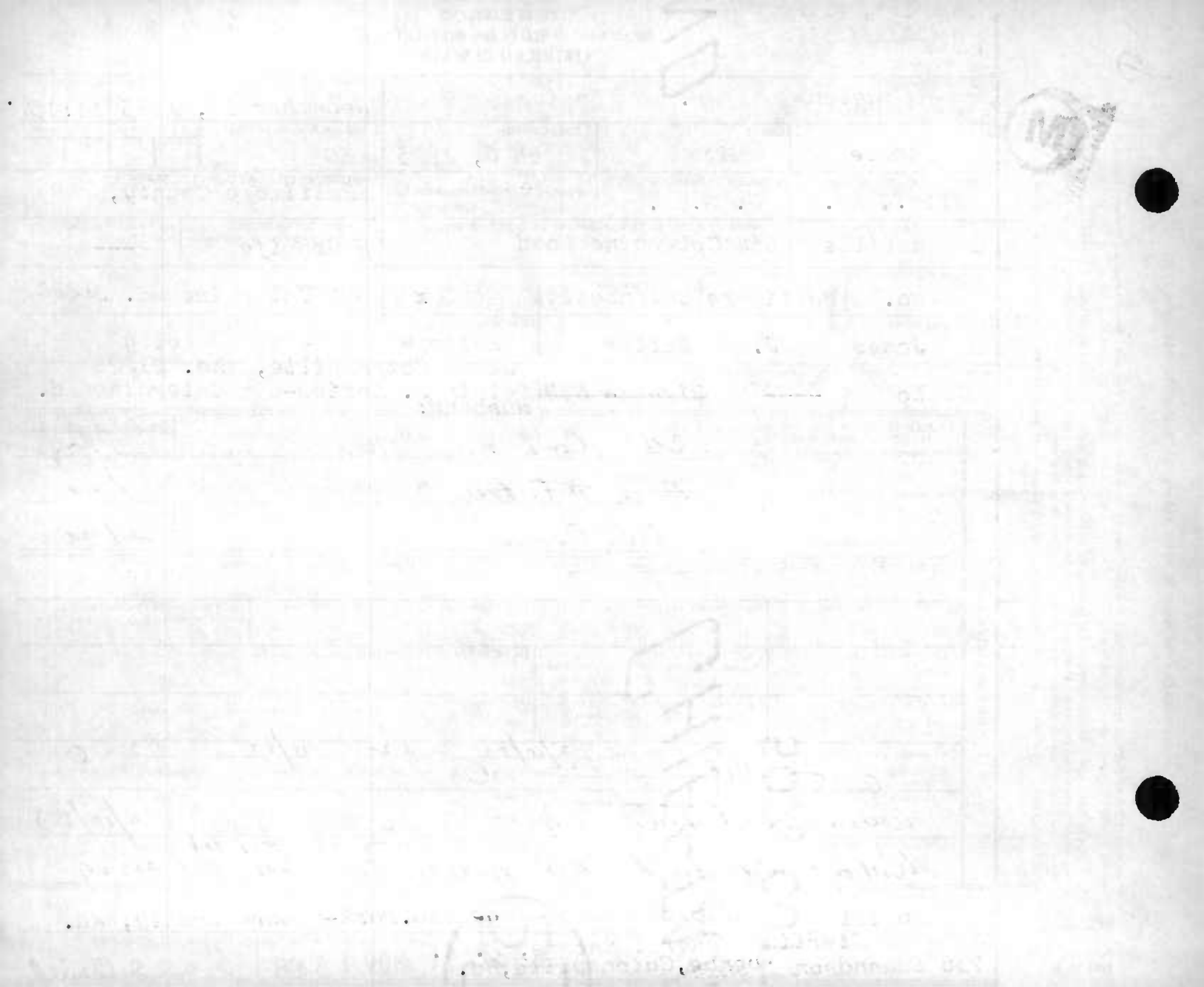
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/19/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Park-Howard County, Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <i>Sterling Funeral Estate, P. A.</i> <i>736 Edmondson Avenue, Catonsville, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 18 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Canine</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

XC 215 05 4375

1. DECEASED NAME (TYPE OR PRINT) **AKA Charles John Boswell** LAST**CHARLES JOHN****BOSWARVA**2a. DATE OF DEATH MONTH DAY YEAR  
**NOVEMBER 4, 1983**2b. HOUR P M  
**2:00 P M**

3. SEX

**MALE**

4. RACE

**WHITE**

5. DATE OF BIRTH

MONTH DAY YEAR  
**MAY 16 1901**

6. AGE (IN YEARS LAST BIRTHDAY)

**82** YRS.

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

**ENGLAND**

7b. CITIZEN OF WHAT COUNTRY?

**U.S.A.**8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

**BALTIMORE COUNTY** MD.

10. CITY OR TOWN OF DEATH

**FORT HOWARD**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

**VA MEDICAL CENTER**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

**Stationary Engineer**

12b. KIND OF BUSINESS OR INDUSTRY

**Cup Mfg. Co.**

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

**MARYLAND**

13b. COUNTY

**BALTIMORE**

13c. CITY OR TOWN

**BALTIMORE**

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

**1945 DENBURY ROAD**

21222

14. FATHER'S NAME

FIRST MIDDLE LAST  
**Unknown**

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST  
**Unknown**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

**YES**

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

**WWI**

215 05 4375

17. INFORMANT

ADDRESS

**Ruth H. Lavix, Friend, Same**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **SEVERE PNEUMONIA, EDEMA, AND CONGESTION OF LUNGS**

4140  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CARDIOMEGALY AND CORONARY ATHEROSCLEROTIC HEART DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☒ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

**P.M. 19**

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐ AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE

22a. I certify that ~~he~~ (this hospital) attended the deceased from **NOVEMBER 8** 19 **82**, to **NOVEMBER 4** 19 **83**, that (if we) lost saw the deceased alive on **NOVEMBER 4** 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. ~~XX we~~ (did) ~~XXXX~~ view the body after death.

22b. SIGNATURE

**M. Singh mo**

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒

22c. DATE SIGNED

**11/05/83**

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

**MANONANJAN P. SINGH, M.D.**

22e. ADDRESS

**VA MEDICAL CENTER, FORT HOWARD, MD**

23a. BURIAL, CREMATION, REMOVAL

**Burial**

23b. DATE

**11/7/83**

23c. NAME OF CEMETERY OR CREMATORY

**Holly Hill Memorial Gardens Baltimore, Md.**

23d. LOCATION

**Baltimore, Md.**

STATE

24. FUNERAL DIRECTOR

**Brudzinski Funeral Home PA 1407 Old Eastern Ave**

25a. DATE REC'D. BY REGISTRAR

**NOV 8 1983**

25b. REGISTRAR'S SIGNATURE

**John J. Connel**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



UNITED STATES DEPARTMENT OF AGRICULTURE

Report of the Commissioner of the General Land Office  
on the Survey of the Public Lands of the United States

for the year ending June 30, 1900

Presented to the Senate and House of Representatives  
at their respective sessions, January 1, 1901

WASHINGTON: GOVERNMENT PRINTING OFFICE  
1901

Published by the Government Printing Office  
under authority of the Senate and House of Representatives

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		XC 5712100		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>LESTER BOUNDS</b>				2a. DATE OF DEATH <b>NOVEMBER 1, 1983</b>				2b. HOUR <b>11:00 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUGUST 25 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>			
10. CITY OR TOWN OF DEATH <b>FORT HOWARD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>VA MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUTCHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>LAUREL</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Grover</b> MIDDLE <b>Bounds</b> LAST				15. MOTHER'S MAIDEN NAME FIRST <b>Gladys</b> MIDDLE <b>Hunter</b> LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>265 09 7908</b>		17. INFORMANT <b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>6951</b> IMMEDIATE CAUSE (a) <b>TOXIC EPIDERMAL NECROLYSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHRONIC RENAL FAILURE</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPTEMBER 6 1983</b> , to <b>NOVEMBER 1 1983</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 1 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Srinivasan L. Narasimhan</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>11/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SRINIVASAN L. NARASIMHAN, M.D.</b>				22e. ADDRESS <b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Nov. 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Md. Veterans Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Crownsville, Maryland</b>	
23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

BP



1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marie E. BOYKIN					2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 11 23 83 9 45 AM				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR AUG. 29 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. COUNTY MD			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HSWE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN EAST POINT					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6318 BOSTON 21222		
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES A. BAKER					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EFFIE MAE WILLIAMS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217 22 1039		17. INFORMANT ADDRESS JOSEPH BOYKIN JR WILLIAMSBURG VA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 cardiac pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) cat cell carcinoma of the lung DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 11/1, 19 83, to 11/23, 19 83, that (1) (we) lost saw the deceased alive on 11/23, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.									
22b. SIGNATURE John P. Joyce MD					22c. DATE SIGNED 11/23/83			22d. ADDRESS	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) John P. Joyce MD					22f. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11/26/83		23c. NAME OF CEMETERY OR CREMATORY OAK LAWN		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD		
24. FUNERAL DIRECTOR NAME J.B. CONNELLY ADDRESS 300 MACE					25a. DATE REC'D. BY REGISTRAR NOV 29 1983		25b. REGISTRAR'S SIGNATURE		

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 3 2 8 7 2 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES E. BRAXTON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-15-1983</b>		2b. HOUR <b>1 40 PM</b>		
3 SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 30, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>STELLA MARIS HOSPICE CARE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Groom</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Horses</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Glyndon</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS <b>Rural</b>		13f. STREET ADDRESS <b>21071</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Eleanor Braxton</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>229-36-1921</b>		17. INFORMANT <b>Pauline Jackson,</b>		ADDRESS <b>Front Royal, Virginia</b>	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Esophageal carcinoma****1509**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dondale R Faulkner MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FAULKNER</b>				22e. ADDRESS <b>Stella Maris 2300 Dulaney Valley Rd. - 21204</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/18/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Morris</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hume Fauquier Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>R. F. Minter</b> <b>Moser Funeral Home, 233 Broadview, Warrenton, Va.</b>				25a. DATE RECD. BY REGISTRAR <b>NOV 18 1983</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 30, 1967

x

Virginia

Robert

Green

Smith

x

Johnson

W. Johnson

Johnson

Johnson

Johnson

Johnson

Johnson, Robert, Virginia

333-6-2007

no

NOV 30, 1967

NOV 30, 1967

Robert Green

NOV 18 1968

Mr. Johnson

Mr. Johnson

Mr. Johnson

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

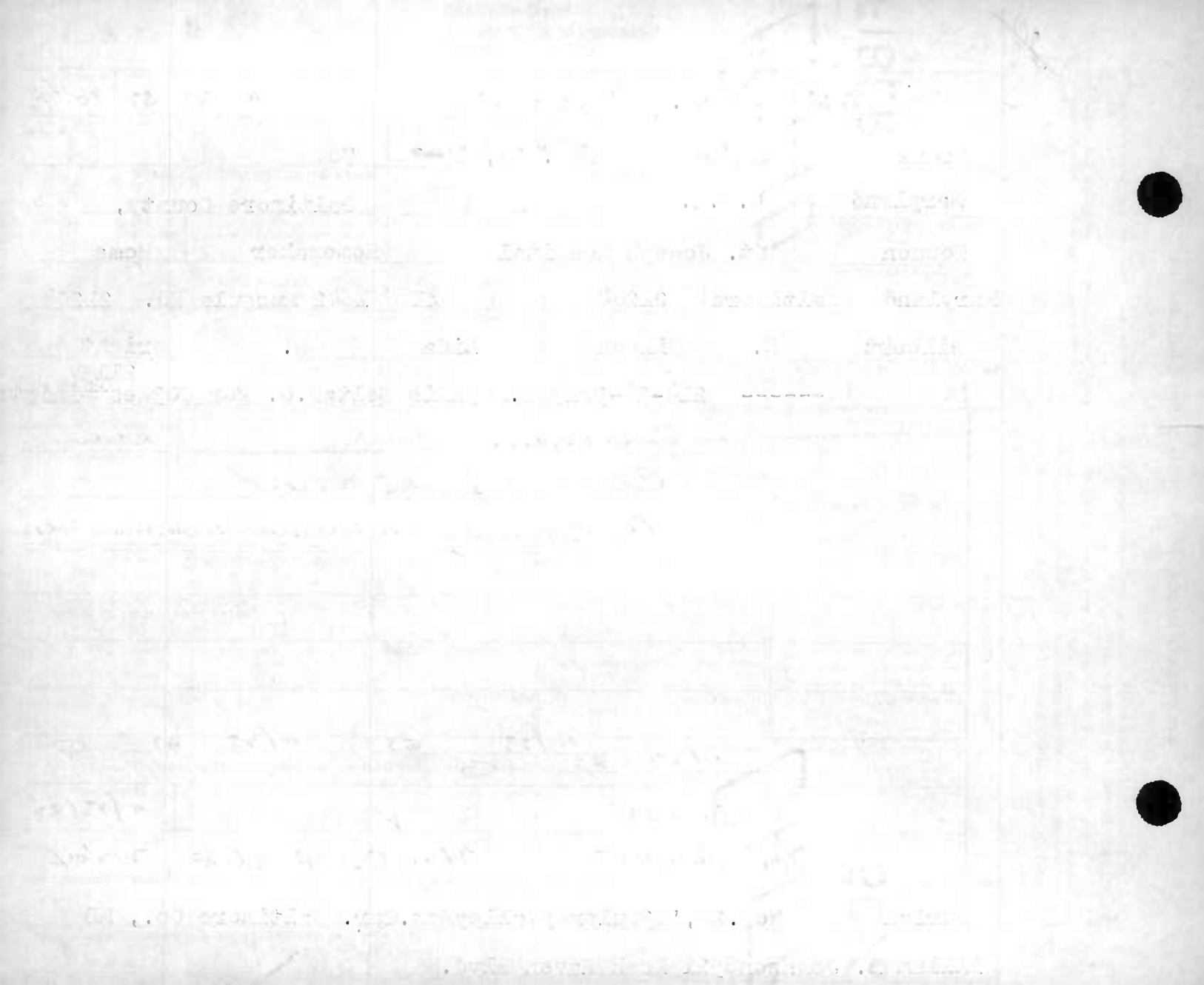
1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHEA O. BREIDENSTEIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 23 83</b>			2b. HOUR <b>10<sup>15</sup> PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 23, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>			
12. CITY OR TOWN OF DEATH <b>Towson</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>		16b. COUNTY <b>Baltimore</b>		16c. CITY OR TOWN <b>21204</b>		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>1642 Mussula Rd. 21204</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>Wilbert N. Wilson</b>				18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lida M. Wright</b>					
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		20. SOCIAL SECURITY NO. <b>214-34-3819</b>		21. INFORMANT ADDRESS <b>21157 D. Phyllis Beltz P.O. Box 803 Westminister</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral aneurysm but decreased cerebral blood flow</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/23</b> , 19 <b>83</b> , to <b>11/23</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/23</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. C. ...</b>			DEGREE <b>L. C. ...</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/23/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. C. ...</b>			22e. ADDRESS <b>7401 OSCAR DRIVE, 21204</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov. 26, '83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem. Gar.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co., MD</b>			
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b>			ADDRESS <b>8521 Loch Raven Blvd.</b>			25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 3 2 8 1 2 9	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) <sup>OR</sup> MARY <sup>MIDDLE</sup> E. <sup>LAST</sup> H. BREIGHNER			2a. DATE OF DEATH MONTH / DAY / YEAR 11/10/83		2b. HOUR 12 P.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH / DAY / YEAR 1/10/11	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County, MD.		
10. CITY OR TOWN OF DEATH Towson	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) STELL MARY'S HOSPITAL Lane Unit		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Essex	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5 Brett Court Apt. 104 21221
14. FATHER'S NAME FIRST MIDDLE LAST William Stansbury		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie LaRue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-28-4756		17. INFORMANT ADDRESS 21201 Rev. Joseph F. Breighner - 320 Cathedral St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) Malignant Lymphoma DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/29, 19 83, to NOV. 11, 19 83, that (I) (we) lost saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 14, 1983		23c. NAME OF CEMETERY OR CREMATORY Taylor's Chapel Cem. Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR 1050 York Road		25b. REGISTRAR'S SIGNATURE NOV 14 1983 John J. Connel	

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U.S.A.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF A DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGE 1 AND 2 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM 1000, IN PAGE 5 OF YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8/130
1. DECEASED NAME (TYPE OR PRINT) William Paul Brown						2a. DATE KNOWN OF DEATH November 20, 1983		2b. HOUR		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Feb. 8, 1956	6. AGE (IN YEARS) 27 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD November 20, 1983		2d. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Fullerton 21236		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8420 Belair Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Intern		12b. KIND OF BUSINESS OR INDUSTRY Clergy		
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Essex 21221		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 828 Dorsey Ave. 21221		
14. FATHER'S NAME FIRST MIDDLE LAST Vernon Base Brown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Gomeringer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 219 76 4181		17. INFORMANT ADDRESS Vernon B. Brown, Father Same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation from Hanging 9530 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE Charles O'Donnell, Deputy			MEDICAL EXAMINER (SPECIFY) 7501 Y rk Rd. Towson, Md. 21204					DATE SIGNED 11/20/83		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/23/83		23c. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co., Md.			
24. FUNERAL DIRECTOR Brazdzinski Funeral Home PA 1407 Old Eastern Ave					25a. DATE REC'D. BY REGISTRAR NOV 22 1983					25b. REGISTRAR'S SIGNATURE John J. [Signature]

11/2/81  
11/2/81

Application for Housing

11/2/81

11/2/81

11/2/81



11/2/81

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE FUNERAL DIRECTOR. PAGE 5 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										28731 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH BRUNO										2a. DATE KNOWN OF DEATH ESTIMATED November 22, 1983 2b. HOUR OF DEATH 2 PM											
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 19, 1904		6. AGE (IN YEARS) LAST BIRTHDAY 79 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD November 22, 1983		2d. HOUR OF DEATH 2 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD.									
10. CITY OR TOWN OF DEATH PARKVILLE				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8008 HIGHPOINT ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF-EMP.				12b. KIND OF BUSINESS OR INDUSTRY CONCRETE Co.									
13a. STATE MARIANA				13b. COUNTY BALTIMORE		13c. CITY OR TOWN PARKVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 8008 HIGHPOINT ROAD 21234											
14. FATHER'S NAME FIRST MIDDLE LAST CARMSLO BRUNO						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 214 14 0622		17. INFORMANT ADDRESS FAMILY RECORDS													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: 9550 IMMEDIATE CAUSE (a) <u>Gunshot Wound of Skull</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>45 Cal Pistol Wound of Head</u>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>				TITLE (SPECIFY) Deputy Medical Examiner								DATE SIGNED 11/22/83									
EXAMINER'S NAME (TYPE OR PRINT) CHARLES F. O'DONNELL				ADDRESS 7501 YORK ROAD, Towson																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE Nov. 25, 1983		23c. NAME OF CEMETERY OR CREMATORY Green Mount Csm.				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND											
24. FUNERAL DIRECTOR NAME EVANS CHAPEL OF MEMORIES				ADDRESS 8800 HARFORD ROAD				25a. DATE REC'D BY REGISTRAR DEC 2 1983				25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>									





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Leo F. BUBCZYK			2a. DATE OF DEATH MONTH DAY YEAR November 10, 1983			2b. HOUR 1:35pm	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 04 03 10	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FRANKLIN SQUARE HOSPITAL		12a. USUAL OCCUPATION HOME BUILDER		12b. KIND OF BUSINESS OR INDUSTRY HOUSING		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE MARYLAND		13b. CITY OR TOWN BALTIMORE		13c. STREET ADDRESS / ZIP CODE 7920 BRIDGE AVE. 21237			
14. FATHER'S NAME FIRST MIDDLE LAST FRANK BUBCZYK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIANNA THOMAS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 213010369		17. INFORMANT ADDRESS FRANK BUBCZYK 7920 BRIDGE AVE.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer Of The Lungs With Metastases To The Bone And Liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Severe Dehydration

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 7, 1983, to November 10, 1983, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on November 10, 1983, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.					
22b. SIGNATURE M. Anderson M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 11/10/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Anderson, M.D.		22e. ADDRESS 9000 Franklin Square Drive 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 11/14/83	23c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY	23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. BALTO. MD.
24. FUNERAL DIRECTOR NAME ADDRESS J. J. Walsh 1211 Chesapeake Ave 21237		25a. DATE REC'D. BY REGISTRAR NOV 14 1983	25b. REGISTRAR'S SIGNATURE John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



NAME  
CHANDLER

CAUCASIAN  
USA

03 10 58

ROSAVILLE  
MARIAN

BALTIMORE ROSA

ROSAVILLE  
3833 BRIDGE AVE. S1933

PLANK

RUSSIAN

MARIAN

THOMAS

NO

S1930389

3833 BRIDGE AVE. S1933

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Sybil W Buehler</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>November 15 1983</i>			2b. HOUR <i>4:30</i> P <sub>M</sub>				
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>July 15 1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>74</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Towson</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>302 Stevenson Lane</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>R.N.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		
13a. STATE <i>Md</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Towson</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>302 Stevenson Lane 21204</i>		
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>218-24-0182</i>		17. INFORMANT ADDRESS <i>Mr. Pezzulla 301 Equitable Bldg. Towson, Md. 21204</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>4148</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Hypertension</i>										
19a. DATE OF OPERATION <i>9/27</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9/27</i> , 19 <i>79</i> , to <i>11/15</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>June 6</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>George E. LaRocco</i>			DEGREE			22c. DATE SIGNED <i>11/15/83</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George E. LaRocco IM</i>			22e. ADDRESS <i>7600 Oslee Drive Suite 311 106050N, Md</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			23b. DATE <i>11/15/83</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>					ADDRESS <i>Balto., Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 21 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

MEDICAL CERTIFICATION

29

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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 of this form should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



4:30

Hospital

302 Stevenson Lane

302 Stevenson Lane 21204

Towson

Towson, Md. 21204

Mr. Perin

212-24-0182

No

212-24-0182

Remove

Baltimore, Md.

Anthony Board

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARIE J. BULLINGER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-28-83</b>		2b. HOUR <b>6:07 PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 9 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST Joseph Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Balto</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>3412 Kentucky Ave</b>		13f. CITY OR TOWN <b>Baltimore</b>		13g. STATE <b>MARYLAND</b>		13h. ZIP CODE <b>21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Reese Strasburg</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Kroder</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>219-40-5745</b>		17. INFORMANT ADDRESS <b>Baltimore, Md. 21213</b> <b>Evelyn Balcerzak 3412 Kentucky Ave</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram Neg Septicemia</b> <b>5990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UTI = Septic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/28/83</b> , 19____, to <b>11/28/83</b> , 19____, that (I) (we) lost saw the deceased alive on <b>11/28/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Beatriz Dizon, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/28/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Beatriz Dizon M.D.</b>				22e. ADDRESS <b>St. Joseph Hospital Towson, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec 2, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
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24. FUNERAL DIRECTOR NAME <b>Dippel Funeral Homes, Inc.</b> ADDRESS <b>7110 Belair Road</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



*[Faint, mostly illegible handwritten text on lined paper. Some words like 'The', 'and', 'of', 'is', 'are' are visible.]*

NOV 10 1966

NOV 10 1966



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Theodore M Burkhoff			2a. DATE OF DEATH MONTH DAY YEAR November 27, 1983			2b. HOUR 8:05 pm			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 5/4/07		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.			
10. CITY OR TOWN OF DEATH ROSSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANKLIN SQ.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD.			13b. COUNTY BALTO		13c. CITY OR TOWN ESSEX		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13 WARREN RD 21221	
14. FATHER'S NAME FIRST MIDDLE LAST FREDERICK BURKHOF					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JUNK					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNK			16b. SOCIAL SECURITY NO. 216 09 6169		17. INFORMANT ADDRESS ELEANORA BURKHOF ABOVE					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 DUE TO, OR AS A CONSEQUENCE OF (b) Small Cell Indifferated Carcinoma Left Upper Lobe DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11c

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (this hospital) attended the deceased from Oct 25, 1983, to Nov 27, 1983, that (we) last saw the deceased alive on Nov 27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (view the body after death.)		22b. SIGNATURE Waclaw Kazimierzczak, M.D.		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Waclaw Kazimierzczak, M.D.		22e. ADDRESS 9000 Franklin Square Dr., 21237					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/1/83		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD.	
24. FUNERAL DIRECTOR NAME J.G. CONNELLY				ADDRESS 300 MACE		25a. DATE REC'D. BY REGISTRAR NOV 29 1983	
						25b. REGISTRAR'S SIGNATURE John J. Connelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before final disposition.





104 S 2 1033

12/18

104 S 2 1033

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Joseph P. Callahan</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11 / 4 / 83</i>		2b. HOUR <i>4:10 P.M.</i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 20 12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Randallstown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Meridian - Randallstown</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Guard</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bendix Co.</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>Maryland</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Sykesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Phillip ----- Callahan</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Elizabeth ----- Strotman</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-10-8208</i>	
17. INFORMANT ADDRESS <i>Mr. Patrick J. Callahan, 1209 Westminster, Md. 2115</i>		17. INFORMANT ADDRESS <i>Nottingham Rd.</i>					

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *CVA*

*4292*

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *ASCVD*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>9/82</i> , 19____, to <i>11/3/83</i> , 19____, that (I) (we) last saw the deceased alive on <i>11/3/83</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William Wilfong</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>11/4/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <i>P.O. 66, Garrison, Md 41055</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 7, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, 130 E. Fort Ave. Balto. Md. 21230</i>				25a. DATE REC'D. BY REGISTRAR <i>NOV 8 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Conish</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 32 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP \_\_\_\_\_

*[Faint, illegible handwriting across the page]*

11/11/11

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COPIES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (Type or Print) <b>GWENDOLYN P. CAMPBELL</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11-26-83</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-13-02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE COUNTY <b>INDIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>BANDOLUSCOWN</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County Gen. Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry Phillips</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Phillips</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-34-7345</b>		17. INFORMANT ADDRESS <b>Gweny C. Beveridge Same as # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MEGASTATIC CARCINOMA</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-26-83</b> to <b>11-26-83</b> , that (I) (we) lost saw the deceased alive and above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>INDIRA P. REDDY</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11-26-83</b>	
22d. PHYSICIAN'S NAME (THROUGH PRINT) <b>INDIRA P. REDDY</b>		22e. ADDRESS <b>BALTIMORE COUNTY GEN Hosp BANDOLUSCOWN, MD, 21133</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md.</b>	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gish</b>	
1630 Edmondson Avenue, Catonsville, Md. 21228							

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME

(TYPE OR PRINT)

FIRST MIDDLE LAST  
IRIS CAPASSO M. CAPASSO

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

11 15 85 9:05 PM

3. SEX

F

4. RACE

W

5. DATE OF BIRTH

MONTH

DAY

YEAR

5 19 19

6. AGE (IN YEARS LAST BIRTHDAY)

64

IF UNDER 1 YEAR

IF UNDER 24 HRS

MONTHS

DAYS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

BALTIMORE COUNTY MD.

10. CITY OR TOWN OF DEATH

BALTIMORE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

STELLA MARIS HOSPITAL UNIT

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Bookkeeper

12b. KIND OF BUSINESS OR INDUSTRY

H.J. Knott

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

BALT.

13c. CITY OR TOWN

BALT

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

1100 N HUNTER ST.

Apt 11-2

21201

14. FATHER'S NAME

FIRST MIDDLE LAST

Shelley

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST

Robertson

FIRST MIDDLE LAST

Regina

FIRST MIDDLE LAST

Dillon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

214-03-4526 A

17. INFORMANT

ADDRESS

Italo Capasso - Same as #13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Circulatory Resp. arrest.

4960

DUE TO, OR AS A CONSEQUENCE OF

(b) COPD.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last

saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

KR Faulkner MD

DEGREE

ATTENDING PHYSICIAN ☐MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

11 15 83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

FAULKNER

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial Cremation

23b. DATE

11-19-83

23c. NAME OF CEMETERY OR CREMATORY

Westview

23d. LOCATION

Baltimore

COUNTY

STATE Maryland

24. FUNERAL DIRECTOR

Ruck Towson Funeral Home, Inc. 1050 York Road

Towson, Md. 21204

25a. DATE REC'D. BY REGISTRAR

NOV 17 1983

25b. REGISTRAR'S SIGNATURE

John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

BP

XXXXX Corporation 11-12-83  
Towson, Md. 21204

Baltimore

Maryland

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COPIES

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 8 / 3 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTOPHER J CARR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 12 83</b>			2b. HOUR <b>12:08 P M</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 22, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Saint Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALES MAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CHURCH GOODS</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>			13b. COUNTY <b>BALTIMORE</b>		13c. CITY OR TOWN <b>TOWSON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHRISTOPHER CARR</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE SULLIVAN</b>			13e. STREET ADDRESS / ZIP CODE <b>305 E. JOPPA RD. 21204</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW1 101-30-4568A</b>		17. INFORMANT ADDRESS <b>ALBERTA S. CARR 305 E. JOPPA RD. 21204</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY INSUFFICIENCY</b> <b>4821</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTERSTITIAL LUNG DISEASE</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b> <b>9 YRS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>PROBABLE PSEUDOMONAS PNEUMONIA / CONGESTIVE HEART FAILURE</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>September 23, 1983</b> to <b>November 12, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 12, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE <b>Randolph Whipp</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RANDOLPH G. WHIPP</b>			22e. ADDRESS <b>ST. JOSEPH HOSPITAL BALTO. MD</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>NOV. 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DULANEY VALLEY MEM. GUNS COCKEYSVILLE BALTO. MD.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>MITCHELL WIEDEFELD HOME</b>			ADDRESS <b>6500 YORK RD. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 17 1983</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Baltimore County

Township of Towson



13

13

13

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Fred M Cash</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11-1-83</b>			2b. HOUR <b>12:45pm</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 13, 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tenn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sheet Metal</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bendex</b>		
13a. USUAL RESIDENCE 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Balt</b>			13c. CITY OR TOWN <b>Baltimore</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Cash</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lula Unk</b>			15a. STREET ADDRESS <b>5711 Whitby Rd 21206</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>413-14-4114</b>			17. INFORMANT ADDRESS <b>Wanda R Jackson Same As 13c</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2502 Hypertensive coma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis mellitus</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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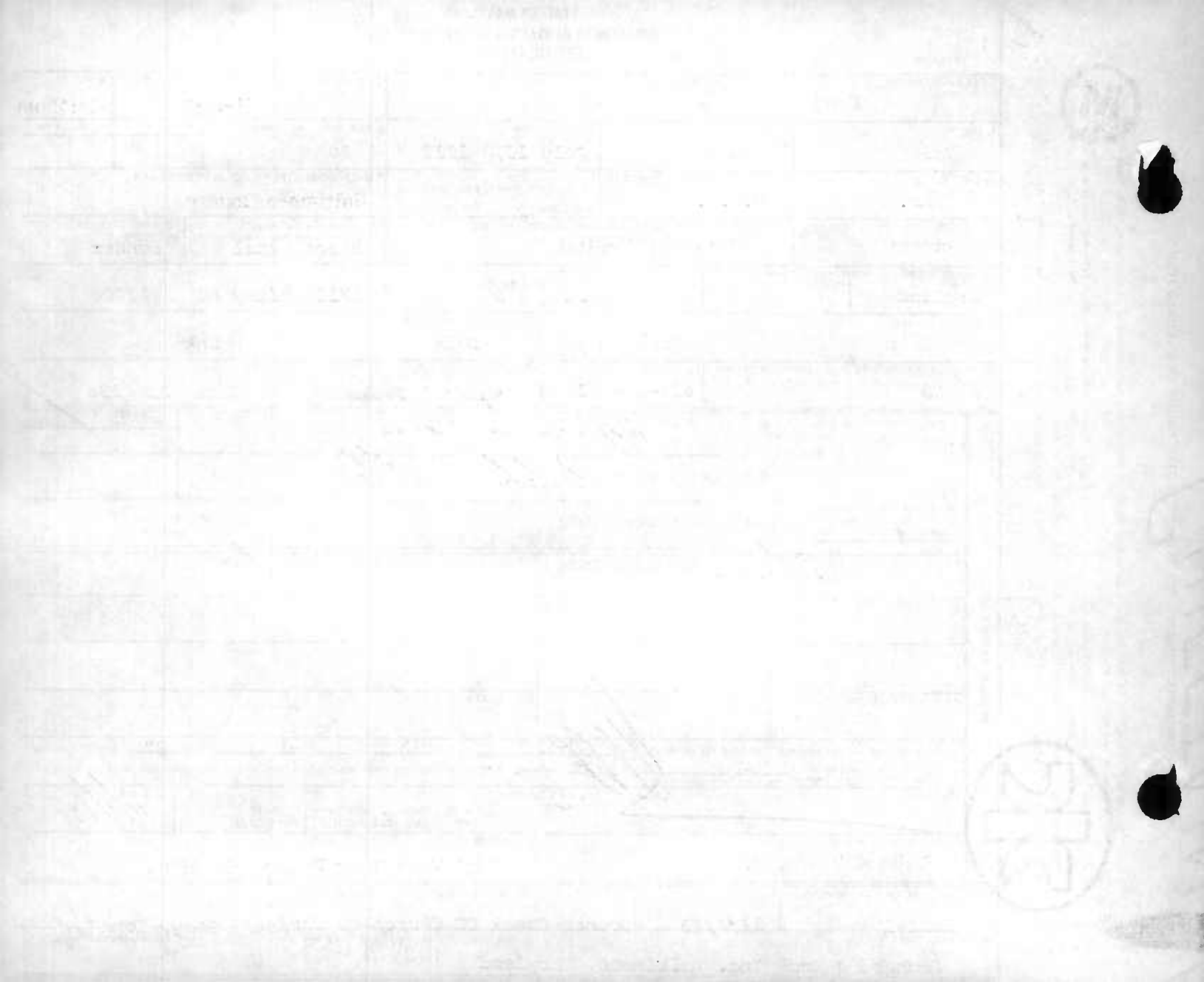
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Septicemia**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-31</b> , 19 <b>83</b> , to <b>11-1</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>11-1</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE <b>Eddie Nakhuda, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/1/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eddie Nakhuda, M.D.</b>				22e. ADDRESS <b>7620 York Road Towson Md 21204</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boones Creek Church Of Christ</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Gray, Tenn</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25. DATE REC'D. BY REGISTRAR <b>NOV 2 1983</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES R CATHELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV 9TH 1983</b>		2b. HOUR <b>4:00 P</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jan 8, 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>X BALTIMORE COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST. JOSEPH HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Carpenter</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Vincent Cathell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Gonzaga Sheridan</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-05-1164</b>		17. INFORMANT <b>Nancy Casper</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275 IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO RENAL</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>FAILURE, CHRONIC OBSTRUCTIVE PULMONARY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISEASE &amp; GASTROINTESTINAL BLEEDING</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>NOV. #3RD 19 83</b> to <b>NOV. 9TH 19 83</b> , that (if <input checked="" type="checkbox"/> we) lost saw the deceased alive on <b>NOV. 9th 19 83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Natividad D. de Leon, M.D.</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/9/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NATINDAD, D. DE LEON, MD</b>		22e. ADDRESS <b>7620 YORK RD TOWSON, MD 21204</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Nov 12, 83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Doppel Funeral Homes, Inc.</b>		ADDRESS <b>7110 Belair Road Baltimore, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 through 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 27 1953

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

NOV 27 1953

BALTIMORE COUNTY

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

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NOV 27 1953

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS JOSEPH</b>		2a. DATE OF DEATH MONTH <b>11</b> DAY <b>19</b> YEAR <b>83</b>		2b. HOUR <b>6:24</b> PM
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>13</b> YEAR <b>1911</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Balto. Co. Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Guard</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Armco Steel Co.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Reisterstown</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Coughlin</b> LAST <b>Coughlin</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>Keavney</b> LAST <b>Keavney</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-10-0719</b>		17. INFORMATION ADDRESS <b>James J. Coughlin</b> <b>Same</b>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>SHOCK (CARDIOGENIC)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 Hrs</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>INTERIOR WALL MYOCARDIAL INFARCTION</b>		
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> , 19 <b>83</b> , to <b>11/19</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Steven Steinberg MD</b>		DEGREE <b>MD</b>	22c. DATE SIGNED <b>11/19/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEVEN STEINBERG</b>		22e. ADDRESS <b>3502 CROYDON RD BALTIMORE, MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Nov. 23, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore City, Maryland</b>
24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b>		25a. DATE RECD. BY REGISTRAR <b>NOV 28 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>



Thomas J. Campbell

White

Salisbury Court

W. J. L.

at 10 level 10

North Co. of the

W. J. L.

His name is

W. J. L.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <del>CER NIGLIA</del> ROSA J. CERNIGLIA			2a. DATE OF DEATH MONTH DAY YEAR Nov. 23 1983			2b. HOUR 12 50 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 24 99		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore County General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY Home		13. STREET ADDRESS 901 Southbridge Rd.					
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Geppi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annietta Citrano					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-20-55		17. INFORMANT ADDRESS 6617 Frederick Ave Catonville 21228			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

SEIZURE DISORDER

DUE TO, OR AS A CONSEQUENCE OF

(b) Cerebro-Vascular Accident

DUE TO, OR AS A CONSEQUENCE OF

(c) INTERCOSTAL CARDIO-VASCULAR

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

GASTROINTESTINAL BLEEDING

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 22 1983 to Nov. 23 1983 that (I) (we) lost the deceased alive on Nov. 23 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ramon S. Pimental				22c. DATE SIGNED Nov. 23/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAMON S. PIMENTAL	
22e. ADDRESS 7501 LIBERTY ROAD				22f. CITY OR TOWN Baltimore			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/28/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore	
24. FUNERAL DIRECTOR NAME Farley Funeral Home				25. DATE REC'D. BY REGISTRAR NOV 28 1983			
26. REGISTRAR'S SIGNATURE John J. Connel				27. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

Page 40

~~Received of Mr. J. C. Williams Nov. 2, 1924~~

Amount \$11.45

For balance of 1924

Received of Mr. J. C. Williams Nov. 2, 1924

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>EMMA EDITH CHALLANDES</b>					2a. DATE OF DEATH MONTH <b>11</b> DAY <b>05</b> YEAR <b>83</b> HOUR <b>8:15</b> MIN. <b>P</b>				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>01</b> DAY <b>01</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MULTI-MEDICAL NURSING CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Board of Education</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b></b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2 Lyndale Ave. 21236</b>	
14. FATHER'S NAME FIRST <b>Phillip</b> MIDDLE <b></b> LAST <b>Zimmerman</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Marie</b> MIDDLE <b></b> LAST <b>Intlekefer</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>079-09-3004</b>		17. INFORMANT ADDRESS <b>2103 Wilker Ave Balto., 21234</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>sepsis</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>aspiration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>6</b> , 19 <b>83</b> , to <b>11</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alan M. Shorofsky MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN M. SHOROFSKY MD</b>		22e. ADDRESS <b>1708 WHITEHEAD RD BALTIMORE MD</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>11-9-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Balto.</b> COUNTY <b></b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home</b>		7401 Belair Rd. ADDRESS <b>Balto., Md. 21236</b>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Nov 14 1983</b>			



New York

Tolson

Board of

Education

Commission

Report

of the

Commission

on the

State of

Education

in the

United

States

of America

1912



1912-13

1912-13

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Grace E. Chapman</i>			2a. DATE OF DEATH MONTH <i>11</i> DAY <i>28</i> YEAR <i>83</i>		2b. HOUR <i>9:20</i> <sup>M</sup>
3. SEX <i>F</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH <i>2</i> DAY <i>19</i> YEAR <i>1907</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>76</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>County</i> MD.	
10. CITY OR TOWN OF DEATH <i>Towson</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dulaney-Towson Thoroughfare</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY	13c. CITY OR TOWN <i>Baltimore</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <i>Samuel</i> MIDDLE <i>F.</i> LAST <i>Evans</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Anna</i> MIDDLE <i>Beiber</i> LAST <i>Beiber</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	
16b. SOCIAL SECURITY NO. <i>216-46-3749</i>		17. INFORMANT ADDRESS <i>21212 3 B</i> <i>Miss Mary O'Neill 369 Homeland Southway Apt</i>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*4360*

DUE TO, OR AS A CONSEQUENCE OF

(b) *Old CVA, Abdominal aneurysm*

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

*Convulsive seizures*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 <i>83</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <i>AT</i> , 19 <i>71</i> , to <i>Nov 28</i> , 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>Nov 28</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					

22b. SIGNATURE <i>Chas. O'Donovan</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <i>11/30/83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Charles O'Donovan, M.D.</i>		22e. ADDRESS <i>9 E. Chase Street Baltimore, Maryland</i>	

23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>	23b. DATE <i>12-1-1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	23d. LOCATION CITY OR TOWN <i>Baltimore</i> COUNTY <i>Maryland</i>
24. FUNERAL DIRECTOR NAME <i>Ruck Towson Funeral Home, Inc.</i> ADDRESS <i>1050 York Road Towson, Maryland</i>		25a. DATE RECD. BY REGISTRAR <i>DEC 1 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a reasonable time after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO



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2000 COLL

Charles O'Leary, N.Y.

Charles O'Leary, N.Y.

DEC 1

1900



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1E shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28746

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
GERTRUDE				CHIRCUS	SUN.	NOV.	6,	1983	3:50 PM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
FEMALE	WHITE	NOV. 3, 1893		90	MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
RUSSIA	USA			BALTIMORE COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
RANDALLSTOWN	OLD COURT NURSING HOME		HOUSEWIFE		HOME				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MARYLAND			BALTIMORE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3601 FORDS LANE (21215)				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
ABRAHAM		RAFALSKY		MTRIAM UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		220-44-3208		MRS. DORIS BEARMAN 7 SLADE AVE. (21208)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4370 IMMEDIATE CAUSE (a) <u>Chronic Brain Disease</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 441	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Atrophy &amp; Sclerosis</u>								2545	
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular Disease</u>								2072	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Coronary Artery Disease, Congestive Heart Failure, Sick Sinus Syndrome, Permanent</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan 1963, to Nov 1983, that (I) (we) lost saw the deceased alive on Nov 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. [Signature]</u> MD				DEGREE		22c. DATE SIGNED 11/7/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE RAMAPURAM				22e. ADDRESS 3502 CROYDON RD. (21207)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		11/8/83		SHAAREI TFILOH CEM		BALTIMORE, BALTIMORE, MD.			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				NOV 10 1983		<u>[Signature]</u>			

TO: DIRECTOR, FBI (100-371100) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY, AKA; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, FEBRUARY NINE LAST.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE

INTERVIEW OF JAMES EARL RAY, CONDUCTED BY NEW YORK OFFICE, FEBRUARY

NINE LAST. RAY STATED THAT HE HAD BEEN IN NEW YORK CITY ON FEBRUARY

NINE LAST, AND THAT HE HAD BEEN IN CONTACT WITH SEVERAL INDIVIDUALS

WHO WERE ASSOCIATED WITH THE BLACK PANTHER PARTY. RAY STATED THAT

HE HAD BEEN ADVISED BY ONE OF THESE INDIVIDUALS THAT HE SHOULD

CONTACT WITH AN INDIVIDUAL WHO WAS CURRENTLY IN NEW YORK CITY.

RAY STATED THAT HE HAD BEEN ADVISED THAT THIS INDIVIDUAL WAS

CURRENTLY IN NEW YORK CITY, AND THAT HE SHOULD CONTACT WITH HIM.

RAY STATED THAT HE HAD BEEN ADVISED THAT THIS INDIVIDUAL WAS

CURRENTLY IN NEW YORK CITY, AND THAT HE SHOULD CONTACT WITH HIM.

RAY STATED THAT HE HAD BEEN ADVISED THAT THIS INDIVIDUAL WAS

CURRENTLY IN NEW YORK CITY, AND THAT HE SHOULD CONTACT WITH HIM.

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CURRENTLY IN NEW YORK CITY, AND THAT HE SHOULD CONTACT WITH HIM.

RAY STATED THAT HE HAD BEEN ADVISED THAT THIS INDIVIDUAL WAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH-16 25M  
(VRA 15.4) 1/79

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		M	
Allen James Christy			Nov. 8 1983		5 A	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR		8. UNDER 24 HRS
M	W	Oct 9 1920	63 YRS.	MONTHS	DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
10A	10B	10C		10D		
IOWA	USA			BALTO COUNTY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
WHITE MARSH	10520 VINCENT RD				AWKINNES	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?
MD.		BALTO		WHITE MARSH		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS		
FIRST MIDDLE LAST		FIRST MIDDLE LAST		21162		
EDGAR CHRISTY		ELSA SHARPENBURG		10520 VINCENT RD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS		
UNK		47912 4871		FAKE CHRISTY ABOVE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial Infarction						
2500 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio Sclerotic CVD						
DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from Nov 4 1983 to Nov. 8 1983, that I saw the deceased alive on Nov 4 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		
William A. Tyson		Box 158 Kingsville Md. 21087		NOV 14 1983		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION		11/9/83		SECURITY PROSSER		BALTO. MD.
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
J.G. CONNELLY		300 MACE		NOV 14 1983		John J. Connel

1971

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

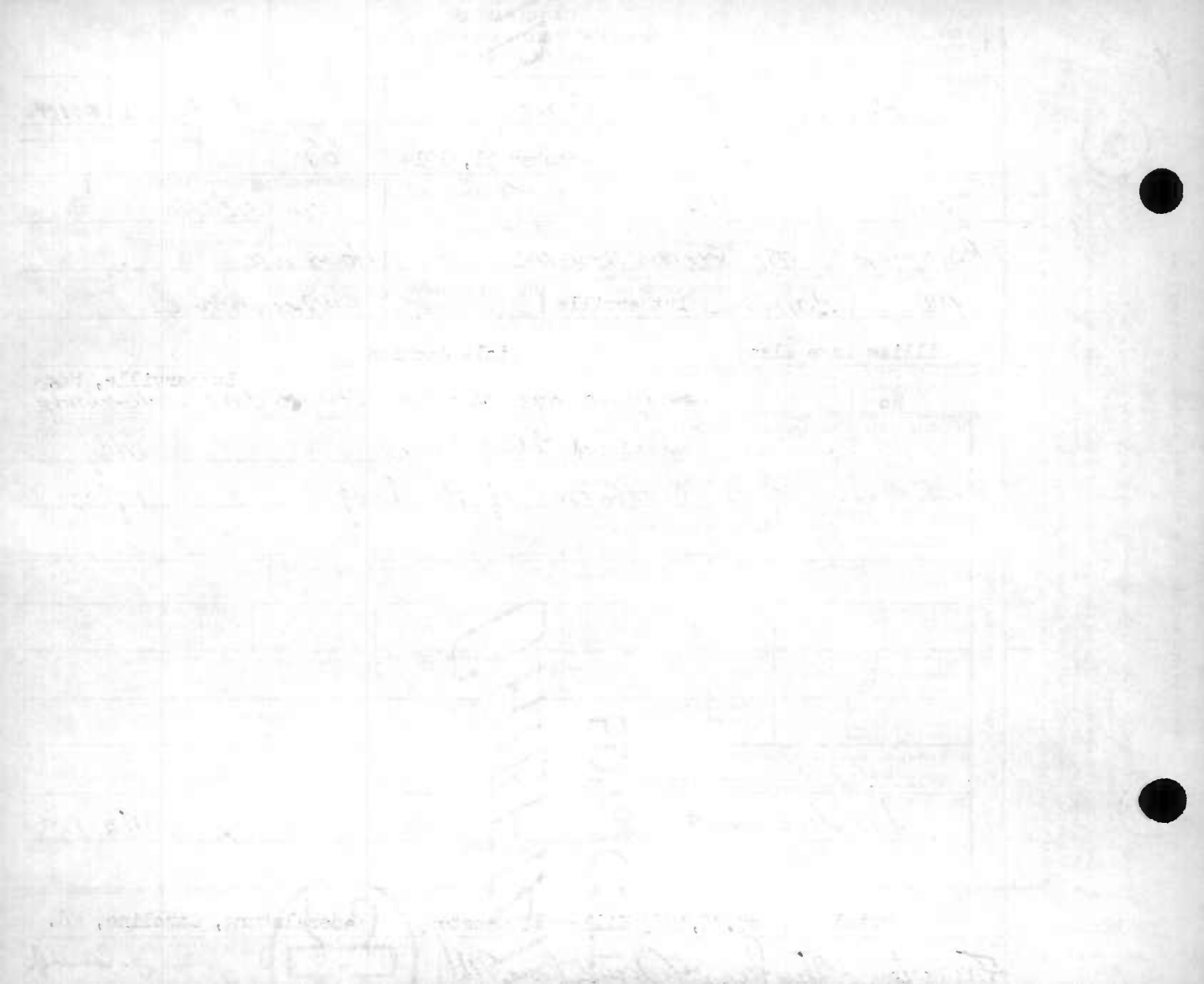
1. DECEASED NAME (TYPE OR PRINT) <i>Emily E. Clark</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>11-21-83</i>		2b. HOUR <i>10:16 PM</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>October 31, 1914</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>M.D.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>County, Balto.</i> MD.		
10. CITY OR TOWN OF DEATH <i>Baltimore</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Josephs Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD.</i>		13b. COUNTY <i>Baltimore</i>	13c. CITY OR TOWN <i>Lutherville</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>104 Greenridge Rd. 21093</i>
14. FATHER'S NAME FIRST MIDDLE LAST <i>William Lake Elzey</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Viola Jackson</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>195-05492</i>	17. INFORMANT ADDRESS <i>Husband Charles Clark - 104 Greenridge</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>massive hemorrhage</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of the lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>1 year</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>A M de la Monte, MD</i>		DEGREE		22c. DATE SIGNED <i>11/21/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Nov. 25, 1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Federalburg, Caroline, Md.</i>
24. FUNERAL DIRECTOR NAME <i>Frankton - Howkins Federalburg, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>NOV 28 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

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TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed withing-72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 2 8 7 4 9			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>OLIVIA GRACE CLAWSON</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>November 8, 1983</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 22, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD	
10 CITY OR TOWN OF DEATH <b>Towson</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baldwin</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hampton Lee Watson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Olivia Webb</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-40-1686</b>		17. INFORMANT ADDRESS <b>Clarence W. Clawson, Sr. same as # 13e</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>4029</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HASCD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. <b>Stroke, Hypertension, Atherosclerosis, Obesity</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 9, 1983</b> to <b>Nov. 8, 1983</b> , that (I) (we) last saw the deceased alive on <b>Oct. 9, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Elliott S. Harris, M.D.</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>11/10/83</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)				23e. ADDRESS <b>8100 Harford Road 21234</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-12-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	



RECEIVED  
NOV 17 1964  
U.S. AIR FORCE  
OFFICE OF THE SECRETARY  
WASHINGTON, D.C.

TO: SAC, NEW YORK  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
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10. [illegible]

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11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
15. [illegible]  
16. [illegible]  
17. [illegible]  
18. [illegible]  
19. [illegible]  
20. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
CHARLES LLOYD CLAYPOOLE				November		19 83		1:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 72 HRS	
Male	White	June 18, 1902		81		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.			Baltimore County MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Towson	Greater Baltimore Medical Center						Petroleum		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
		Maryland		Baltimore		Towson		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS / ZIP CODE					
FIRST MIDDLE LAST		FIRST MIDDLE LAST		204 E. Joppa Road 21204					
Robert Garland Claypoole		Eva Clements Lloyd							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No		215-03-4552		Mrs. C.L. Claypoole 204 E. Joppa Road 21204					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Gram-Negative Sepsis									
1850 } DUE TO, OR AS A CONSEQUENCE OF									
Lung and Perinephric/Nephric Abscesses									
DUE TO, OR AS A CONSEQUENCE OF									
Carcinoma of Prostate									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 29, 1983, to Nov. 19, 1983, that (I) (we) lost saw the deceased alive on Nov. 19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
John E. Adams M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				Nov. 20, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
John E. Adams, M.D.				6701 N. Charles St., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		11-21-83		Greenmount		Baltimore Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd, 21212				NOV 28 1983		John J. Connelley			

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J. W. Lee

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JOSEPH LOCILOVA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 22 83</b>		2b. HOUR <b>1250 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>Caucasion</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 11 54</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>29</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Randallstown</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baltimore County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machine Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>American Bank Stationary</b>	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Locheam</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6854 Westridge Road 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Sam Cocilova</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Whipple</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-4800-46</b>		17. INFORMANT ADDRESS <b>Mrs. Eileen Cocilova</b> <b>6854 Westridge Road Baltimore, MD. 21207</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5185 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>DISSEMINATED INTRAVASCULAR COAGULATION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ADULT RESPIRATORY DISTRESS SYNDROME - SEPSIS (PNEUMOCOCCAL)</b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11-16-1983</b> , to <b>11-22-1983</b> , that (I) (we) lost saw the deceased alive on <b>11-22-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Dr. Depestre</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11-22-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. DEPESTRE</b>		22e. ADDRESS <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11-25-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Pikesville Baltimore MD.</b>		
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>		
24. FUNERAL DIRECTOR ADDRESS <b>8728 Liberty Road Randallstown, MD. 21133</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
FIRST MIDDLE LAST		NOV 16, 1983		5:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH	
Male		White		MONTH DAY YEAR	
				May 17, 1919	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)	
Virginia		U.S.A.		64 YRS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
TOWSON		ST. JOSEPH HOSPITAL		BALTIMORE COUNTY MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Auto Repairman					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Baltimore		Fullerton	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
Louis Cofflin		Nettie Not Known			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		231-03-9285		Carol L. Hurd 4245 Slater Ave. 21236	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARRHYTHMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RESPIRATORY INSUFFICIENCY</b> <b>ANOXIC ENCEPHALOPATHY</b> (c) <b>RUPTURED ABDOMINAL AORTIC ANEURYSM</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
				16	
22a. I certify that (this hospital) attended the deceased from <b>OCT 1</b> , 19 <b>83</b> , to <b>NOV 18</b> , 19 <b>83</b> , that (we) last saw the deceased alive on <b>NOV 16</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
		22e. ADDRESS			
		7620 YORK RD 21204			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		Nov 19 1983		Moreland Memorial	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Baltimore Maryland		NOV 17 1983		John J. Conner	
24. FUNERAL DIRECTOR NAME ADDRESS					
Leonard J. Ruck, Inc. Baltimore, Maryland					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Environ Biol Fish (2015) 98:113–124

Leistungsbewertung: 2,00 von 4,00

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James A. Buck, Inc. Baltimore, Maryland



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

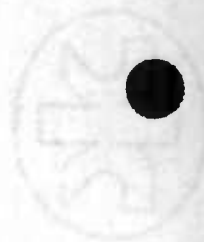
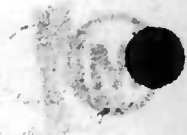
BP.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT)				2b. HOUR			
George Ernest Coldewy				11 13 83 5 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		March 18, 1904		79 yrs.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
New Jersey		USA				Balt. County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Towson		Stella Maris		Food Broker		Self employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?			
13a. STATE				13e. STREET ADDRESS			
Maryland				3 Silver Circle, Pasadena, Md.			
13b. COUNTY				13c. CITY OR TOWN			
A.A.Co.				Pasadena			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
14a. FIRST MIDDLE LAST				15a. FIRST MIDDLE LAST			
Francis Coldewy				Annie Carley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Yes				215-10-7758			
17. INFORMANT				ADDRESS			
Mrs. Mary E. Ryden, Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) ADVANCED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE							
4292							
DUE TO, OR AS A CONSEQUENCE OF							
(b) SEPTICEMIA							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from July 31, 1980 to Nov. 12, 1983, that (I) (we) last saw the deceased alive on Nov. 7, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
						11-13-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Eddie Nakhuda				Stella Maris			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Nov. 16, 1983		Baltimore Cemetery		Baltimore, Maryland	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
McCutty Funeral Home, Mt. & Tickneck Rds, Pasadena Md. 21122				NOV 15 1983			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR
 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Violet Ruby Cole</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 1 1983</b>			2b. HOUR M <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 27 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77 76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore, Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Parkville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3221 Putty Hill Ave.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
13a. STATE <b>Md</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Parkville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>3221 Putty Hill Ave. 21234</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christopher Hanes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruby M. Winks</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>215-22-7713</b>		17. INFORMANT <b>Peggy J. Chandler</b>		ADDRESS <b>3221 Putty Hill Ave</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular insufficiency</b> <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic cardio</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH <b>1 year</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Diabetes Mellitus Type I</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/13</b> , 19 <b>83</b> , to <b>Nov. 1st</b> , 19 <b>83</b> , that (I) (we) lost <b>7/21</b> <b>81</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Hans J. Koetter</b>						DEGREE		22c. DATE SIGNED <b>11/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Hans J. Koetter, M.D.</b>						22e. ADDRESS <b>7600 Osler Drive</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11-3-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Co. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1983</b>			
						25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen C. COLES			2a. DATE OF DEATH MONTH DAY YEAR November 21, 1983			2b. HOUR 4:25 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.				
10. CITY OR TOWN OF DEATH Rossville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Franklin Sq. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY at home		
13a. STATE Md.		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 5927 Glenock Ave.		
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Roberts		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Kalhtenboch						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-22-9355		17. INFORMANT John H. Coles		ADDRESS same		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 4151 DUE TO, OR AS A CONSEQUENCE OF (b) Massive multiple pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from Nov. 7, 1983, to Nov. 21, 1983, that (we) last saw the deceased alive on Nov. 21, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Allan Gittman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 11/21/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allan Gittman, MD				22e. ADDRESS 9000 Franklin Square Dr., 21237			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11-25-83		23c. NAME OF CEMETERY OR CREMATORY Lorraine		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc				ADDRESS 5305 Harford Rd.		25a. DATE REC'D. BY REGISTRAR NOV 23 1983	
						25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified ahead of time.

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U.S. AIR FORCE

U.S. AIR FORCE  
HEADQUARTERS  
WASHINGTON, D.C.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Willie Gilmer COMER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 24, 1983</b>		2b. HOUR MIN. <b>1:40P</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 24, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Baltimore</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Supr.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James G. Comer</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary (Mollie) Cormany</b>		13e. STREET ADDRESS / ZIP CODE <b>Balto, Md. 1052 N. Iris Ave, 21205</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>228-01-4424</b>		17. INFORMANT ADDRESS <b>Balto, Md. 21205</b>		17. INFORMANT NAME <b>Katherine L. Comer, 1052 N. Iris Ave,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myeloid Leukemia</b> <b>2051</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Gastro Intestinal Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (x) (this hospital) attended the deceased from <b>November 11, 1983</b> to <b>November 24, 1983</b> , that (x) (we) last saw the deceased alive on <b>November 24, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>L. Albiol M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/24/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Loreto Albiol, M.D.</b>		22e. ADDRESS <b>9000 Franklin Square Dr., 21237</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>OaKlawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Schimunek Funeral Home, 3331 Brehms La,</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Guy B. COMPTON		Burnett		November 2, 1983				3:41 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		Dec. 27, 1921		61		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		USA				Baltimore County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rossville		Franklin Square Hospital				Inspector		Metal-Steel	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS?		13c. STREET ADDRESS			
Maryland Harford Edgewood				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1405 Clearview Road 21040			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Watson -- Compton				FIRST MIDDLE LAST Rose -- Sutherland					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WWII		228-14-9440		Mrs. Beulah T. Compton, 1403 Clearview Road Edgewood, Md. 21040			

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial infarction

4100

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Ventricular failure

DUE TO, OR AS A CONSEQUENCE OF

(c) Congestive heart failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from Nov. 2, 1983, to November 2, 1983, that (we) last saw the deceased alive on above, (we) (did) (did not) view the body after death.		22b. SIGNATURE IRENE F. DISANZA M.D.		DEGREE M.D.		22c. DATE SIGNED 11/2/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
IRENE F. DISANZA		9000 Franklin Square Dr., 21237					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Nov. 5, 1983		Bel Air Memorial Gardens, Bel Air		Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard K. McComas III, Abingdon, Md. 21009				NOV 4 1983			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

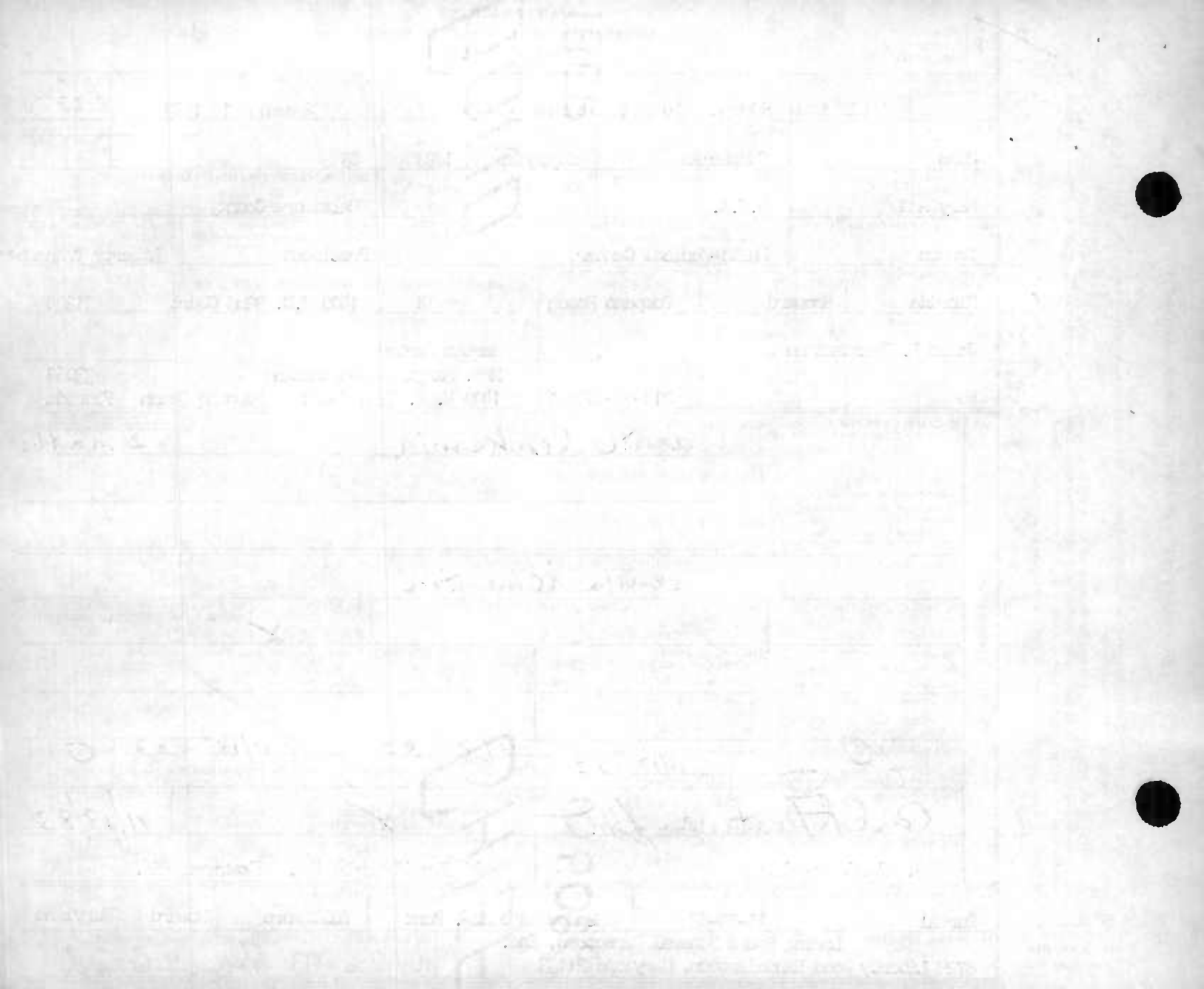


O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use on the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>William Elmer Constantine, Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>November 18 1983</b>			2b. HOUR <b>8:15 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 19 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7b. IF UNDER 24 HRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.					
12. CITY OR TOWN OF DEATH <b>Towson</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Multi-Medical Center</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>President</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Liberty Transfer</b>			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Florida</b>		13b. CITY OR TOWN <b>Broward</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>1400 N.E. 32nd Court</b>		13e. ZIP CODE <b>99999 21204</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James L. Constantine</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bertha Gerber</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-03-3522 A</b>		17. INFORMANT <b>Mrs. Margaret Constantine</b>		17a. ADDRESS <b>1400 N. E. 32nd Court</b>		17b. CITY OR TOWN <b>Pompano Beach</b>			
17c. STATE <b>Florida</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute leukemia</b> <b>2080</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>senile dementia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> 19 <b>83</b> , to <b>11/18</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Carl Freidman</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>11/19/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Carl Freidman</b>				22e. ADDRESS <b>660 Kenilworth Dr. Towson, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11-22-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Howard Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			
8728 Liberty Road Randallstown, Maryland 21133											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Helen Cook				2a. DATE OF DEATH MONTH DAY YEAR 11 11 83			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 17 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7c. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County MD.	
10. CITY OR TOWN OF DEATH Dundalk		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 248 Patapsco Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Dundalk		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John D'Antoni		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Danna		13e. STREET ADDRESS 248 Patapsco Avenue 21222			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-16-6069		17. INFORMANT William F. Cook		ADDRESS 248 Patapsco Ave. Balto., MD. 21222	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) <u>PANCREATIC CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANA SARCA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> , 19 <u>83</u> , to <u>11/11</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/10/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Debra Wertheimer MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>11/11/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Debra Wertheimer, M.D.				22e. ADDRESS 6216 Eastern Avenue, Baltimore, MD 21224			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/14/83		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue, Dundalk, MD 21222				25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Carney</u>	

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>HARRY Thomas COOLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 24, 1983</b>			2b. HOUR P M <b>2:51 P M</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 15, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <b>68</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wilmington, N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co</b>							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry T. Cooley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Azile Hewlett</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 212 05 4993A</b>		17. INFORMANT ADDRESS <b>Mrs. Virginia S. Cooley 228 Gaywood Road -12</b>			

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **RESPIRATORY FAILURE**

**3201**  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **MENINGITIS, PNEUMOCOCCAL, OTITIS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ACUTE**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 18TH</b> , 19 <b>83</b> , to <b>NOV. 24th</b> , 19 <b>83</b> , that (we) (we) lost saw the deceased alive on <b>NOV. 24TH</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles Hoesch</i>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES HOESCH, M D</b>		22e. ADDRESS <b>7620 YORK RD TOWSON, MD 21204</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11/25/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>MITCHELL-WIEDEFELD HOME, INC. 6500 York Rd.</b>				25a. DATE REC'D. BY REGISTRAR <b>DEC 01 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



RESPIRATORY FAILURE

HEPATIC, ENDOCRINE, BILIRUBIN

ACUTE

NOV 1954

NOV 1954

NOV 1954

NOV 1954

NOV 1954

NOV 1954

NOV 1954

NOV 1954

NOV 1954

NOV 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>CHARLOTTE G. COOPER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 11 '83</b>			2b. HOUR <b>11:30A<sub>M</sub></b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 23 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY, MD</b>			
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Balto.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>203 Cedarcroft Rd. 21212</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Junius D. Grimes</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Wharton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>216-46-3927</b>		17. INFORMANT ADDRESS <b>Elliott R. Cooper Jr. Richmond, Va.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4310</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MASSIVE INTRAVENTRICULAR CRANIAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MASSIVE INTRAVENTRICULAR CRANIAL HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/08</b> , 19 <b>83</b> , to <b>11/11</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>T. Firth MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>11/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS FIRTH, M.D.</b>				22e. ADDRESS <b>GBMC - 6701 N. CHARLES STREET 21204</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>11-12-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 WEST PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES EDWARD COPE		20. DATE KNOWN OF DEATH ESTIMATED 11 7 83		26. HOUR 2050
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 21 1934	6. AGE (IN YEARS) 49	21. DATE PRONOUNCED DEAD 11 7 83
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County	
10. CITY OR TOWN OF DEATH Essex 21221	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24 "A" Glenwood Rd.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter	12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Eastpoint	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 8046 Wynbrook Rd. 21224
14. FATHER'S NAME FIRST MIDDLE LAST James E. Cope		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Monnie Tilman		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 240 44 8555	17. INFORMANT ADDRESS Marcelene June Cope, Wife Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4148 IMMEDIATE CAUSE (a) Chronic ischemic myocardial disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Chronic alcoholism				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE J. Crossan O'Donovan		TITLE (SPECIFY) M.D. Deputy		DATE SIGNED 11/7/83
EXAMINER'S NAME (TYPE OR PRINT) J. CROSSAN O'DONOVAN		ADDRESS 2112 DUNDALK AVE., BALTO., MD. 21222		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 11/11/83	23c. NAME OF CEMETERY OR CREMATORY Cross Creek Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Fayetteville, N.C.	
24. FUNERAL DIRECTOR Brazdzinski Funeral Home		25a. DATE REC'D. BY REGISTRAR NOV 14 1983		25b. REGISTRAR'S SIGNATURE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 28763			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HIRAM E CORNELIUS, Sr.						2a. DATE OF DEATH MONTH DAY YEAR 11 24 83				2b. HOUR 7:10P.M.	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 17 27		6. AGE (IN YEARS LAST BIRTHDAY) 56		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsburgh		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE COUNTY MD					
10. CITY OR TOWN OF DEATH TOWSON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6701 NORTH CHARLES STREET (GBMC)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver-Quinn			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.						13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Shawley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMATION ADDRESS 4050 Wilkens Ave. Balto., Md.		17. INFORMATION ADDRESS Mrs. Rosemary Cornelius, Sr. #21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) HEART BLOCK Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACIDOSIS (c) SEPSIS/CANCER DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 1 hr										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 99	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I (this hospital) attended the deceased from 11-23, 19 83, to 11-24, 19 83, that (I (we) lost saw the deceased alive on 11-24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I (we) did (did not) view the body after death.											
22b. SIGNATURE Charles C. Cummings, MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 11-24-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES C. CUMMINGS, MD						22e. ADDRESS 6701 NORTH CHARLES STREET (GBMC)					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 29, 1983		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.		23e. DATE REC'D. BY REGISTRAR NOV 28 1983			
24. FUNERAL DIRECTOR G. Truman Schwab		5151 Balto. Nat'l. Pike #21229		25a. REGISTRAR'S SIGNATURE John J. Conner							

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Mr.

Violent

Joseph

Yes Korean

216-20-2215 Mrs. Rosemary Cornelius, R. 21539

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Mr.

6701 NORTH CHARLES STREET (1946)

6701 NORTH CHARLES STREET, W

Box 25, 1050 New Cathedral Ave., Balto.

Human Rights Div. Baltimore, Md. 21201

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 1- FOR  
 STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Florence M Cotner</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>November 30, 1983</b>			2b. HOUR M <b>M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 1, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1226 Black Friars Circle</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1915 Burnwood Rd 21239</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Fisher</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann Forbes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>193-28-1422</b>		17. INFORMANT ADDRESS <b>Mrs Mary A Warnkessel Same As 13e</b>				

 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
 PART I. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) HEART MYOCARDIAL INFARCTION  
 DUE TO, OR AS A CONSEQUENCE OF  
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
 (b) ACUTE PERIPHERAL ISCHEMIA  
 DUE TO, OR AS A CONSEQUENCE OF  
 (c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>82</u> , to <u>11/30</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/30/83</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leonard J Ruck Inc.</b>				22e. ADDRESS <b>5800 Edmondson Ave Baltimore, Maryland</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>12/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b>				25. DATE REC'D. BY REGISTRAR <b>DEC 1 1983</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy D. Cottman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>11 - 13 - 83</b>			2b. HOUR <b>12<sup>00</sup> AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 - 14 - 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Catonsville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Summit Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Baltimore</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>116 University Pkwy. Apt. 1116</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Calvin Powell Dryden</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Carter</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>216-52-0616</b>			17. INFORMANT <b>Elizabeth C. Barringer</b>			ADDRESS <b>115 S. Rolling Rd. Catonsville, MD</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

1749

IMMEDIATE CAUSE (a)

Carcinoma of breasts

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

unknown

DUE TO, OR AS A CONSEQUENCE OF

(b)

Carcinoma of Breasts, bilateral

unknown

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION <b>1974</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of Breast</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I <del>was</del> hospital) attended the deceased from <b>2-28-86</b> , to <b>11-13-83</b> , that (I <del>was</del> ) last saw the deceased alive on <b>11-12-83</b> , and that in (my <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I <del>was</del> ) (did not) view the body after death.							
22b. SIGNATURE <b>Martin L. Singewald M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>11-14-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Martin L. Singewald, M.D.</b>				22e. ADDRESS <b>11 E. Chase St., Baltimore, Md. 21202</b>			

23a. BURIAL, CREMATION, REMOVAL (REIFY) <b>Cremation</b>		23b. DATE <b>11/14/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Md.</b>	
24. FUNERAL DIRECTOR <b>Leroy M. &amp; Russell C. Witzke Funeral Homes P.A.</b> <b>1630 Edmondson Avenue, Catonsville, Md. 21228</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ESSE LEONA CRABBIN</b>				2b. HOUR <b>11 28 1983 6:35 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 12, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>83 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE CO., MD.</b>	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GREATER BALTIMORE MEDICAL CR.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>21204</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Thomas Grove</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ellen Mock</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-80-1714</b>		17. INFORMANT ADDRESS <b>Charles A. Crabbins 10 Winterberry St. 2105</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GASTRO INTESTINAL HEMORRHAGE</b> <b>5334</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PEPTIC ULCER DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV. 6 1983</b> to <b>NOV. 28 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOV. 28 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kenneth D. Byerly MD</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>11/28/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH D. BYERLY, M.D.</b>				22e. ADDRESS <b>GREATER BALTO. MED. CENTER 6701 N. CHARLES ST. BALTO.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Dec. 1, '83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>William E. Johnson</b> ADDRESS <b>8521 Loch Raven Blvd.</b>				25a. DATE REC'D. BY REGISTRAR <b>NOV 29 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Coughlin</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 3 28767			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DOROTHEA L. CRAWFORD</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>11 20 83</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 29 13</b>		6. AGE (IN YEARS, LAST BIRTHDAY) <b>70</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>TOWSON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>(GBMC) 6701 NORTH CHARLES STREET</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sales</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Timonium</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Theodore Belbin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Hoffsted</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>220-32-3215</b>		17. INFORMANT ADDRESS <b>Terry T. Crawford, 8 Krisswood Ct., 21236</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MASSIVE HEMORRHAGE</b> <b>4178</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>RUPTURE OF PULMONARY ARTERY</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>SEPTIC SHOCK</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>83</b> , to <b>11-20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-20</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Kenneth D. Byesly</i>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>11/20/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH D. BYESLY</b>				22e. ADDRESS <b>6701 NORTH CHARLES STREET (GBMC)</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>11/25/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Timonium Balto. Md.</b>	
24. FUNERAL DIRECTOR <i>J. E. Lowell Lemmon</i>				25a. DATE REC'D. BY REGISTRAR <b>NOV 23 1983</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
J. E. Lowell Lemmon, 10 W. Padonia Rd. ADDRESS							

11 20 83 4:45P

CRIMEDRD

DOROTHY

FEMALE

09 29 13

BALTIMORE COUNTY

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(GMC)

6701 NORTH CHARLES STREET

TOWSON

6701 North Charles Street, Towson, MD 21204

Baltimore, Maryland

Collected

Field

Field

Reference

21204

6701-32-3215 Perry T. Crawford, 8 Maryland Ave.,

MASSIVE HEMORRAGE

RUPTURE OF PULMONARY ARTERY

SEPTIC SHOCK

11-20-83

83

11-13

83

11-20-

6701 NORTH CHARLES STREET (GMC)

KENNETH D. BYESLY

11 20 83

11 20 83

6701 North Charles Street, Towson, MD 21204

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. ADVISE YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |   |   |  |   |  |   |   | REG. NO.  |  |
|--|--|-------------------------|---|---|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARGIE A. CRAWFORD</b>   |  |                         |   |   |  |   |  |   |   | 2a. DATE KNOWN OF DEATH<br>MONTH DAY YEAR<br><b>11-15-83</b>                        |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>NEGRO</b> |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JAN 22 1946</b>                    |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY YRS.<br><b>37</b>  |  | 7. IF UNDER 24 HRS.<br>MONTHS DAYS HOURS MIN.<br><b>XX</b>                                      |   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>NOV 11-15-83</b>                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>   |  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Catonsville</b>  |  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Rt.40 Nr. Nuwood Rd.</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>CLERK/WRAPPER GIANT FOODS</b> |   |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  |                         | 13b. COUNTY<br><b>BALTIMORE</b>   |   |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>300-A<sup>N</sup>ATHOL AVE<br/>BALTIMORE, MD. 21229</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALBERT SUTTON</b>   |  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>QUEENIE HORN</b>  |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   | 16b. SOCIAL SECURITY NO.<br><b>130-34-2657</b>                  |   |  |
| 17. INFORMANT<br>ADDRESS<br><b>JAMES E. CRAWFORD/300-A<sup>N</sup>ATHOL AVE<br/>21229</b>  |  |                         |   |   |  |   |  |   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>8120</b><br>Cranio-cerebral trauma<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |  |                         |   |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                         |   |   |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                           |  |   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |   | 21b. TIME OF INJURY<br>MONTH DAY YEAR<br><b>NOV 11-15-83</b>                |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>driver of auto/auto collision</b>                                       |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |                         |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY FARM, ETC.)<br><b>street</b> |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>Rt.40 Nr. Nuwood Rd. Catonsville, Md.</b>   |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |   |   |  |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br><b>Margarita A. Korell</b>   |  |                         |   | TITLE (SPECIFY)<br><b>Assistant</b>   |  |   |  | DATE SIGNED<br><b>11-16-83</b>  |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Margarita A. Korell, M.D.</b>   |  |                         |   | ADDRESS<br><b>111 Penn Street</b>   |  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  |                         |   | 23b. DATE<br><b>11/19/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARBUTUS MEMORIAL PK</b>  |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE BALTO. Md.</b>           |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>MARSHALL W. JONES, JR.</b>  |  |                         |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. G... ..</b>  |   |   |  |
| 4101 EDMONDSON AVENUE/BALTO. Md. 21229   |  |                         |   |   |  |   |  |   |   |   |  |

99

Harper's



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JEAN H. CROOKER</b>   |  |   | 2a. DATE OF DEATH<br>MONTH <b>Nov</b> DAY <b>4</b> YEAR <b>1983</b>    |   |   | 2b. HOUR<br><b>6A</b> M   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>Nov</b> DAY <b>25</b> YEAR <b>1919</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS<br>DAYS<br>IF UNDER 24 HRS<br>HOURS<br>MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Canada</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO Co.</b> MD   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>HANOR CARE TOWSON</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Public Relations Advertising</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>21234</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         |  | 13e. STREET ADDRESS<br><b>1824 Glen Ridge Rd. 21234</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>George</b> MIDDLE <b>Scholl</b> LAST <b>Scholl</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Louise</b> MIDDLE <b>Cameron</b> LAST <b>Cameron</b>   |   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>365-18-0931</b>  |  | 17. INFORMANT<br><b>G. Richard Scholl</b>   |   | ADDRESS<br><b>21234</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Multiple Sclerosis</b><br><b>3400</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>12 years</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                               |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                          |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>25 Nov 80</b> to <b>4 Nov 83</b> , that (I) (we) last saw the deceased alive on <b>3 Nov 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>Walter T. Kees</b>  |  |   |  |   |   | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>4 Nov 1983</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER T. KEES</b>   |  |   |  |   |   | 22e. ADDRESS<br><b>Monkton MD 21111</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |   | 23b. DATE<br><b>Nov. 7, '83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Elmwood Cemetery</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Detroit, Michigan</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |  |   |  |   |   | ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |  | 25a. DATE REGD. BY REGISTRAR<br><b>NOV 4 1983</b>  |  |
|  |  |   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |  |  |  |

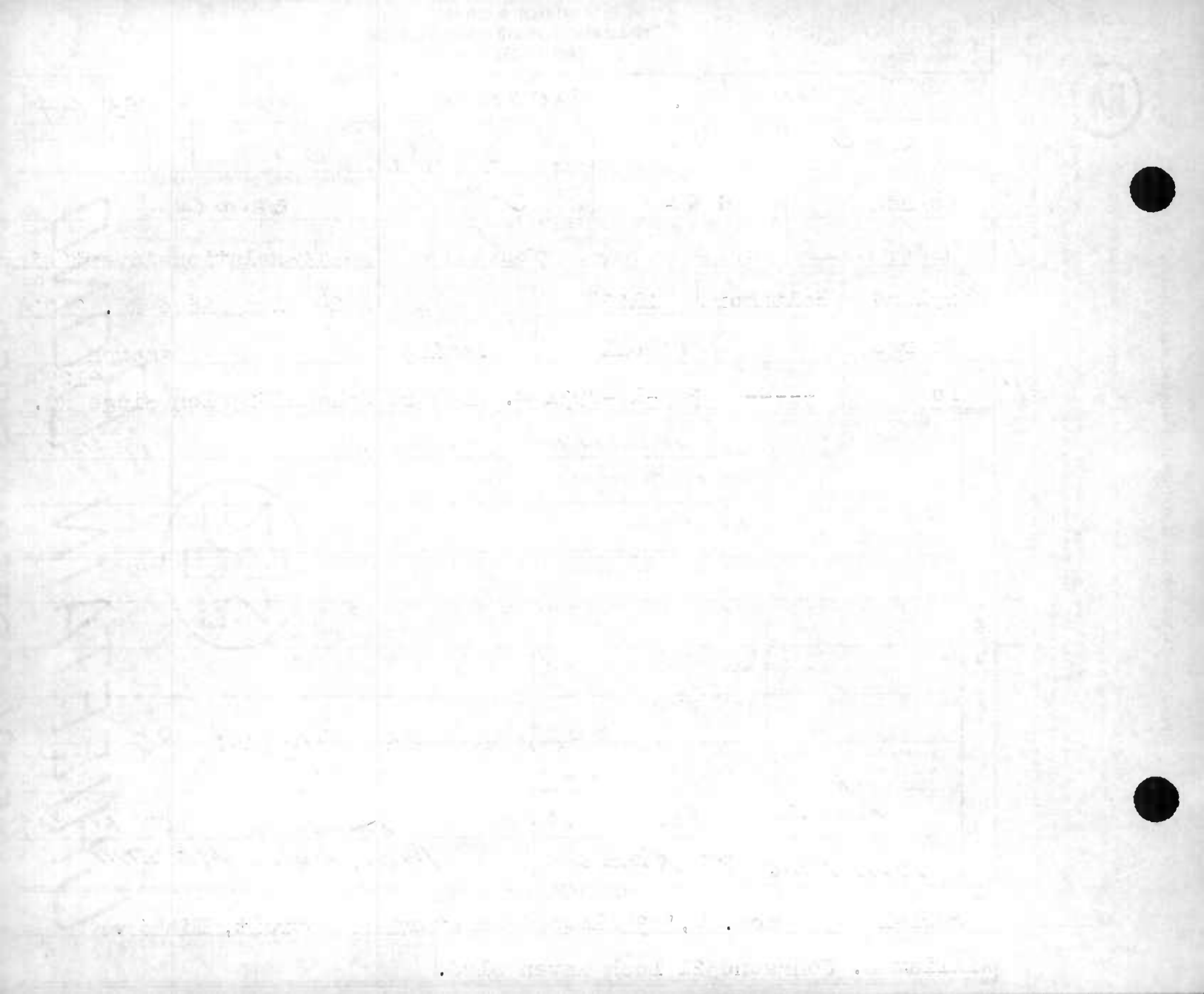
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Wilbur EUGENE CUDMORE</b>                |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 23, 1983</b>                       |   | 2b. HOUR<br><b>6:30P M</b>                              |
| 3 SEX<br><b>Male</b>   | 4 RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 14, 1930</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>53</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                       | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>                                      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Technician</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Electronics</b> |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Harford</b>   | 13c. CITY OR TOWN<br><b>Havre de Grc.</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Wilbur Eugene Cudmore</b>             |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Eleanor Jackson Dawson</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b> |  | 16b. SOCIAL SECURITY NO.<br><b>579-36-9789</b>  |   | 17. INFORMANT<br><b>Betty J. Cudmore, 2304 Nova Dr., Havre de Grace MD, 21078</b>               |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
**1539** IMMEDIATE CAUSE (a) **Poorly differential adenocarcinoma of the colon with hepatic metastasis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 6, 1983</b> to <b>November 23, 1983</b> , that (we) lost the deceased alive on <b>November 23, 1983</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><b>Jameela Arshad, M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>11/23/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Jameela M. Arshad, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>                               |   |

|   |                                   |   |  |
|---|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                               | 23b. DATE<br><b>Nov. 26, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harford Memorial Gdns.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Aberdeen, Harford, Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Tarring Funeral Home, P.A., Aberdeen, MD, 21001-3399</b> |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 30 1983</b>                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as (b), (c) or (d), the medical examiner must be notified.





W. L. S. ... ..



ST. JOSEPH HOSPITAL

NOVEMBER 1, 1913

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

BALTIMORE COUNTY

ST. JOSEPH HOSPITAL

ST. JOSEPH HOSPITAL

CARDIOLOGY ARREST

11/1/13

NOV. 1, 1913

NOV. 1, 1913

ST. JOSEPH HOSPITAL



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |   |
| FIRST MIDDLE LAST<br>Alfred J. D'Ambrosio   |   | MONTH DAY YEAR<br>11-05-83  |   | 1215 M  |   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)   |   |
| Male  | W   | MONTH DAY YEAR<br>JAN 11 1903   |   | 80 YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH  |   |
| WASH. D.C.  | USA   |   |   | BALTO COUNTY MD.  |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |   | 12b. KIND OF BUSINESS OR INDUSTRY               |
| RANDALLSTOWN  | BALTO. COUNTY GENERAL   |   | PHOTO ENGRAVER  |   | STERLING ENG                                    |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE  |   |
| M   | Balt  | RANDALLSTOWN  |   | 3807 MARRIOTSVILLE RD 21133   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LOUIS D'AMBROSIO  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MADELINE MERCURIO  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO                          |   |
|   |   | 16b. SOCIAL SECURITY NO.<br>579-05-7134   |   | 17. INFORMANT<br>ROSE D'AMBROSIO  |   |
|   |   |   |   | ADDRESS<br>3807 MARRIOTSVILLE RD  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) METASTATIC CARCINOMA TO LUNG<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) CARCINOMA OF COLON                                    |   |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)  |   |   |   |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |   |   |   |   |   |
| 22b. SIGNATURE<br>Golan   |   | DEGREE  |   | 22c. DATE SIGNED<br>11/7/83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L.H. GOLOMBEK  |   | 22e. ADDRESS  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br>BURIAL  |   | 23b. DATE<br>11/9/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>HOLY REDEEMER   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO MD.   |   | 24. FUNERAL DIRECTOR<br>NAME<br>WEBER FUNERAL HOME  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1983   |   |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Grieb   |   |   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

RECEIVED

Office of the Secretary of the Interior

Washington, D.C.

May 10, 1906

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 9th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,  
J. H. Thompson

Assistant Secretary

Office of the Secretary of the Interior

Washington, D.C.

Enclosed for you are two copies of the report of the

Commissioner of the General Land Office, dated April 10, 1906.

Very truly yours,  
J. H. Thompson

Assistant Secretary

Office of the Secretary of the Interior

Washington, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>William F. Dauses</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 20, 1983</b>                           |   | 2b. HOUR<br><b>3:05 pm</b>   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 12 1931</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Superintendent</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Lever Brother</b>  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Edgemere</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>2915 Salisbury Avenue 21219</b>  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Dauses</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Marie Haas</b>  |   | ADDRESS<br><b>2915 Salisbury Ave<br/>Balto., MD. 21219</b>                                      |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>Korea 215-24-2026</b>   |   | 17. INFORMANT<br><b>Audrey M. Dauses</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ventricular Rupture</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Acute Myocardial Infarct</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1</b>  |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 20, 1983</b> to <b>November 20, 1983</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>November 20, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated<br>above <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |   |   |  |
| 22b. SIGNATURE<br><b>Irma Ibarra, M.D.</b>   |  |   |   | DEGREE<br><b>MD</b>   | 22c. DATE SIGNED<br><b>11/20/83</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>IRMA IBARRA, M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/23/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Ht. Of Jesus Dundalk</b>                  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Maryland</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1983</b>   |  |
| 7922 Wise Avenue Dundalk, MD. 21222  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>James J. Lawler</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified above.



WHITE PAPER

20% COPIES

Handwritten text, possibly a signature or date, appearing as "1944" and "10/10/44".



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   | REG. NO.   |   |  |  |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |   | FIRST MIDDLE LAST  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  | 2b. HOUR                                     |
| Dorothy J. Davidson   |  |   |  |   |  | 11 16 83   |   |  | M  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN   |  |
| Female  |  | White   |  | 6 7 02  |  | 81 YRS.  |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |  |
| Wash., D.C.   |  | U.S.A.  |  |   |  | Baltimore County MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Balto.  |  | 1226 Black Friars Rd.   |  |   |  | Retired-?  |   |  |  |
| 13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE  |  |   | 13b. COUNTY  |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| Md.   |  |   | Balto.   |   |  |  | Balto., Md. #21228<br>1226 Black Friars Rd.   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |   |  |  |   |  |  |
| ?   |  |   | Jennie S. Clark  |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)                |   | 17. INFORMATION ADDRESS                                    |  |   |  |  |
|   |  |   | 577-42-6968  |   | 8830 Balto. Nat'l Pike Balto., Md.<br>Roland Bounds #21228 |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>metastatic Carcinoma left breast</u><br>1749<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCD w/ Ischemia - Diabetes mellitus</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>11/11</u> 19 <u>83</u> , to <u>11/16</u> 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>11/11</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE  |  |   | DEGREE   |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  | 22c. DATE SIGNED                             |
| JOHN H. SHAW, M.D.  |  |   | 5800 EDMONDSON AVE.<br>BALTIMORE, MD. 21228                            |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |   | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |  |
| Burial  |  |   | 11-19-83   |   | Loudon Pk. Cem.  |  | Balto. Md.  |  |  |
| 24. FUNERAL DIRECTOR  |  |   | 25. DATE REC'D. BY REGISTRAR   |   | 26. REGISTRAR'S SIGNATURE                                  |  |   |  |  |
| G. Truman Schwab  |  |   | 5151 Balto. Nat'l Pike #21229  |   | NOV 21 1983  |  |   |  |  |

Handwritten signature or initials in the bottom left corner.

NOV 21 1983

Faint, mostly illegible text covering the majority of the page, possibly representing a document or report. The text is too light to transcribe accurately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Daisy Martha Davis</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 20, 1983</b>                                 |  | 2b. HOUR<br><b>7:30 pm</b>   |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>OCT. 2, 1897</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b><br>YRS. MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WEST VA.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ESSEX</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSP.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT HOME</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>PARKVILLE</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>8595 MORVEN ROAD</b> 21234                                 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALBERT CHILDERS</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LAURA STEVENS</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>034 053792</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                                    |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Pneumonia and Sepsis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 10, 19 83</b> , to <b>November 20, 19 83</b> , that (I) (we) last saw the deceased alive on <b>November 20, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                               |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Irma Burke</b>   |   | DEGREE<br><b>M.D.</b>  |   | 22c. DATE SIGNED<br><b>11/20/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Irma Burke, M.D.</b>  |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |   | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HUNTINGTON</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>WEST VA.</b>  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPEL OF MEMORIES</b>   |   | ADDRESS<br><b>8800 HARFORD ROAD</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1983</b>                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Melvin B. Davis  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 2, 1983                       |  | 2b. HOUR<br>1720 PM  |
| 3. SEX<br>Male  | 4. RACE<br>White  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 25 1904  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Harford Co., Md.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk 21222  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6800 Mornington Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Physician | 12b. KIND OF BUSINESS OR INDUSTRY<br>Medical   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland   |   |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Dundalk   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Davis  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Lilly                |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-  | 17. INFORMANT<br>ADDRESS<br>Ruth Davis, Wife Same                             |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Chronic generalized ischemic cardiovascular disease<br>4149 DUE TO, OR AS A CONSEQUENCE OF<br>(b) disease 10 year<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) DUE TO, OR AS A CONSEQUENCE OF |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) the hospital attended the deceased from February 19 75, to November 19 83, that (1) (last) saw the deceased alive on November 1 19 83, and that (in my) (some) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (do not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br>J. Crossan O'Donovan  |   |   | DEGREE<br>M.D.  | 22c. DATE SIGNED<br>11/4/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. CROSSAN O'DONOVAN, M.D.   |   |   | 22e. ADDRESS<br>212 Dundalk Ave., Balto., Md. 21222                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial   |   | 23b. DATE<br>11/5/83  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parkwood Cemetery                       |  | 23d. LOCATION<br>Baltimore, Md. COUNTY STATE   |
| 24. FUNERAL DIRECTOR<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave.   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1983                                   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lohr   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Parts 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 28777  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>EVERETTE EDWARD DAWSON</b>  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>November 9, 1983</b>   |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 16, 1899</b>   |  | 2b. HOUR <b>7:06 A.M.</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.   |  | 8. IF UNDER 1 YEAR MONTHS DAYS  |  |
| 10. CITY OR TOWN OF DEATH <b>Owings Mills</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baptist Home Of Maryland</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD  |  | 17a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Edward Dawson</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Williametta Mary Josephine Coles</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |  |  | 16b. SOCIAL SECURITY NO. <b>225-12-3025</b>  |  | 17. INFORMANT ADDRESS <b>Mrs. Margaret D. Carlin 507 Spring Ave. 21093</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1579 IMMEDIATE CAUSE (a) DIFFUSELY METASTATIC ADENOCARCINOMA (PROBABLY PANCREATIC SOURCE)</b>   |  |  |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MONTHS</b> |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____  |  |  |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____  |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. _____   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>10/17/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ABDOMINAL PAIN</b>   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) _____  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE _____   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 5, 1983</b> to <b>NOVEMBER 9, 1983</b> , that (I) (we) lost saw the deceased alive on <b>NOV. 3, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE <b>John G. Lavin</b> DEGREE <b>M.D.</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11-9-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John G. Lavin, M.D.</b>  |  |  |  | 22e. ADDRESS <b>6805 York Road; Baltimore, Md. 21212</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11-12-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carlin</b>  |  |   |  |



101

Charles Edward Dawson  
Married Baltimore  
Virginia U.S.A. x  
Baltimore County  
Retired  
307 Spring Ave. - 21093  
Oct. 16, 1933  
34

Division of Investigation  
(Federal Bureau of Investigation)

10/17/33  
Baltimore

11-12-33  
Baltimore  
11-1-33  
Baltimore

10/17/33  
Baltimore

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |  |   |                                    |  |   |   |  |
|---|--|---|--|---|------------------------------------|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Loretta E. DE DUFOUR</b>                |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 11, 1983</b>   |   |                                    | 2b. HOUR<br><b>4:15P</b> M   |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 30, 1904</b>  |                                    | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b> YRS.                                    |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE Hosp.</b> |  |   |                                    | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                             |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>BALTIMORE</b>                                |   | 13c. CITY OR TOWN<br><b>TOWSON</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>305 E. Joppa Rd 21204</b>                    |  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN BURGER</b> |   |                                    | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA MERGET</b>                  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br><b>105-36-1939</b>  |  | 17. INFORMANT<br><b>MARY ELLEN JONES</b>  |                                    | ADDRESS<br><b>137 PLEASANT HILL Rd.<br/>OWINGS MILLS, MD 21117</b>                   |   |   |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4100</b><br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (this hospital) attended the deceased from <b>Nov. 11, 1983</b> , to <b>Nov. 11, 1983</b> , that (we) last saw the deceased alive on <b>Nov. 11, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) witness the body's death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Donald E. Kerr, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/11/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald E. Kerr, MD</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |   |  |

|   |  |                                    |  |   |  |  |  |
|---|--|------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>       |  | 23b. DATE<br><b>Nov. 14, 1984</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. John's</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Long Green BALTO Md</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>HARTLEY Miller Funeral Homes</b> |  | ADDRESS<br><b>7527 HARford Rd.</b> |  | 25a. DATE RECEIVED BY REGISTRAR<br><b>NOV 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lander</b>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28779

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |   |   |         |  |
|--|--|--|--|---|--|---|---|---|---------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary F DENIKE                       |  |  | 2a. DATE OF DEATH<br>November 25 1983                                  |   |  | 2b. HOUR<br>6:15 A.M.   |   |   |         |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>7 11 1896   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>87 YRS.                                    |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD                   |   |   |         |  |
| 10. CITY OR TOWN OF DEATH<br>Towson  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph's Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home |         |  |
| 13a. STATE<br>Maryland   |  |  | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Timonium                      |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |         |  |
| 14. FATHER'S NAME<br>John  |  |  | 15. MOTHER'S MAIDEN NAME<br>Frances Bumb                               |   |  | 13e. STREET ADDRESS<br>2523 Girdwood Road 21093                               |   |   |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>384-20-7889 |   | 17. INFORMANT<br>Mr. Robert E. DeNike same as # 13 |   |   |   | ADDRESS |  |

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4360

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1 month

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-27, 1983, to 6:15 AM 11-25, 1983, that (I) (we) last saw the deceased alive on 11-25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Hans S. Mahan MD   |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>11-25-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS<br>7620 York Rd. Towson Md  |  |  |  |

|   |  |                       |  |  |  |  |  |
|---|--|-----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation                     |  | 23b. DATE<br>11/26/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Crematory |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. 1050 York Road |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 29 1983             |  | 25b. REGISTRAR'S SIGNATURE<br>John                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHIEF OF POLICE



For the City of New York, I hereby certify that the above is a true and correct copy of the original as the same appears in the files of the Department.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |                                |  |                  |  |
|--|--|--|--|--|--|---|--|--------------------------------|--|------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH  |  | DAY   |  | YEAR                           |  | 2b. HOUR         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST  |  | 11                             |  | 29 83 730 PM     |  |
| VILA, SR. MARY ISABEL de SALES   |  |  |  |  |  |   |  |                                |  |                  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR                |  | IF UNDER 24 HRS. |  |
| FEMALE   |  | CAUCASIAN  |  | 10 15 1901   |  | 82 YRS.   |  | 1 14                           |  |                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                                |  |                  |  |
| PUERTO RICO  |  | U.S.   |  |  |  | BALTO. CO.  |  |                                |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                                |  |                  |  |
| TOWSON   |  | STELLA MARIS HOSPICE   |  | TEACHER  |  |   |  |                                |  |                  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS / ZIP CODE |  |                  |  |
| DC.  |  | BALTO.   |  | WASHINGTON   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 1500 35th ST. 20007            |  |                  |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |                                |  |                  |  |
| FIRST  |  | MIDDLE   |  | LAST   |  | FIRST   |  | MIDDLE                         |  | LAST             |  |
| LUIS   |  | VILA.  |  | ASCENSION MARTINEZ   |  |   |  |                                |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |                                |  |                  |  |
| No   |  | 220-55-7729  |  | 2500 DULANEY VALLEY RD.  |  | TOWSON  |  |                                |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)  |  | PART I. DEATH WAS CAUSED BY:   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |                                |  |                  |  |
| 4409 IMMEDIATE CAUSE (a) PNEUMONIA   |  |  |  |  |  |   |  |                                |  |                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | (b) ADVANCED ARTERIOSCLEROSIS.   |  | 11-21-81   |  |   |  |                                |  |                  |  |
|  |  | (c)  |  |  |  |   |  |                                |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |  |  |  |   |  |                                |  |                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                                |  |                  |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                                |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)   |  |   |  |                                |  |                  |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |                                |  |                  |  |
|  |  | P.M. 19  |  |  |  |   |  |                                |  |                  |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  | CITY OR TOWN  |  | COUNTY                         |  | STATE            |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET   |  |   |  |                                |  |                  |  |
|  |  |  |  |  |  |   |  |                                |  |                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 4/23, 1980, to 11/29, 1983, that (I) (we) lost   |  |  |  |   |  |                                |  |                  |  |
| saw the deceased alive on 11-29-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |                                |  |                  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |   |  |                                |  |                  |  |
| Kendall R Faulkner MD  |  |  |  |  |  |   |  |                                |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  |   |  |                                |  |                  |  |
| KENDALL R. FAULKNER, MD  |  | 2500 DULANEY VALLEY RD. TOWSON.  |  |  |  |   |  |                                |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  | CITY OR TOWN                   |  | COUNTY STATE     |  |
| Burial   |  | Dec. 1, 1983   |  | Georgetown Visitation Convent  |  | WASHINGTON  |  |                                |  | D.C.             |  |
| 24. FUNERAL DIRECTOR   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                |  |                  |  |
| NAME   |  | ADDRESS  |  |  |  |   |  |                                |  |                  |  |
| Mitchell-Wiedefeld Home, Inc.  |  | 6500 York Rd. Balto., Md. 21206  |  | DEC 2 1983   |  |   |  |                                |  |                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

| 1. FOR STATE REGISTRAR   |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 28781  |  |                             |  |
|--|--|---|--|---|--|--|--|---|--|-----------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Dorothy E. Dadd</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 15 1983</b>   |  |  |  | 2b. HOUR P<br><b>2:00 M</b>   |  |                             |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>April 3 1920</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b> YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                           |  |   |  |                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Lutherville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9 Trelawny Court</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>   |  |                             |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Lutherville</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>9 Trelawny Court, 21093</b>   |  |                             |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Frank M. Goetz</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna Mae Flayhart</b>  |  |  |  |   |  |                             |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>-</b>  |  | 17. INFORMANT ADDRESS<br><b>21093 Mrs. Nancy L. Hargest, 9 Trelawny Ct.</b>   |  |  |  |   |  |                             |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Lung Cancer</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mon.</b> |  |   |  |   |  |  |  |   |  |                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |   |  |                             |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                             |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |                             |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |                             |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Oct 9, 1983</b> , to <b>Nov 15, 1983</b> , that (1) (we) lost above, (1) (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |  |   |  |                             |  |
| 22b. SIGNATURE<br><b>Charles Padgett</b>   |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>11/17/83</b>   |  |                             |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles Padgett, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>5601 Loch Raven Blvd.</b>  |  |  |  |   |  |                             |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/18/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cem.</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. City Md.</b>   |  |                             |  |
| 24. FUNERAL DIRECTOR NAME<br><b>J. E. Lowell Lemmon, 10 W. Padonia Rd.</b>   |  |   |  | 24b. ADDRESS<br><b>21093</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |                             |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 28782   |  |  |  |
|--|--|---|--|---|--|--|--|
| FOR<br>1. STATE<br>REGISTRAR   |  |   |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JAMES F. DAVIS</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 20 83</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 7 97</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC-6701 N. CHARLES STREET</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Maintenance</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Cont. Can Co.</b>  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Balto.</b>  |  | 13c. CITY OR TOWN<br><b>Baltimore</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Samuel Davis</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Elizabeth Stein</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>215-01-6062A</b>   |  | 17. INFORMANT<br><b>James F. Davis</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>PNEUMONIA</b><br><b>4960</b><br>IMMEDIATE CAUSE (a)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>COPD =&gt; CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ATHROSCLECTROTIC VASCULAR DISEASE</b> |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>10/20 83</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>10/20 83</b> to <b>11/20 83</b> that (we) last saw the deceased alive on <b>11/20 83</b> and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Raymond A. Nze md</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/20/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. R.A. NZE, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>GBMC - 6701 N. CHARLES STREET</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-23-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  |   |  | 24a. DATE REC'D BY REGISTRAR<br><b>NOV 23 1983</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |
| 24c. ADDRESS<br><b>Balto., Md. 21236</b>   |  |   |  |   |  |  |  |

Lasean Funeral Home  
 11-23-83  
 11-23-83  
 11-23-83

DR. R.A. ZE, M.D.  
 1010 - 6701 . CHARLES STREET

11-20-83  
 11-20-83  
 11-20-83

ATHEROSCLEROTIC VASCULAR DISEASE  
 CHRONIC DESTRUCTIVE PULMONARY  
 DISEASE

F. EUNICIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO. 83 28783  |  |  |  |  |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE   |  | LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  | 2b. HOUR                                     |  |
| CHARLOTTE   |  |  |  |  |  | DE VRIES   |  | 11 10 83  |  | 5 PM   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                  |  |
| FEMALE  |  | WHITE  |  | 9 MONTH 15 DAY 12  |  | 71   |  |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |   |  |  |  |
| New York  |  | USA  |  |  |  | Baltimore County MD.   |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  |  |  |   |  |  |  |
| Rossville   |  | Rossville Manor Care N. H.   |  |  |  |  |  |   |  |  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |  |   |  |  |  |
| housewife   |  | homemaking   |  |  |  |  |  |   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE  |  |  |  |
| Florida   |  |  |  | Lakeworth  |  |  |  | 1717 12th Ave. S. LakeWorth Fla.  |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |  |  |
| Charles Reith   |  |  |  | Margaret Stratton  |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | 13 ADDRESS  |  |  |  |
| no  |  |  |  | 158-30-4821  |  | Paul DeVries   |  | 13 Brooksye Ave. Ringwood, N.J. 07456   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1539  |  |  |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLONIC CANCER  |  |  |  |  |  |  |  |   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10. INTESTINAL OBSTRUCTION, HEPATIC & RENAL FAILURE  |  |  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE  |  |  |  |  |  | DEGREE   |  | 22c. DATE SIGNED  |  |  |  |
| Walter R. Heaven  |  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 11/11/83  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  |  | 22e. ADDRESS   |  |   |  |  |  |
| WALTER R. HEAVEN III  |  |  |  |  |  | 3313 PAPERMILL RD PHOENIX MD 21134   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |  |  |
| Burial  |  | 11-14-83   |  | Pine Crest Cemetery  |  | Lake Worth, Florida  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS   |  |  |  |  |  |  |  |   |  |  |  |
| Dorsey Funeral Home 3525 S. Congress Ave. Lake Worth, Fla.  |  |  |  |  |  |  |  |   |  |  |  |
| NOV 16 1983 REGISTRAR'S SIGNATURE John J. Connel  |  |  |  |  |  |  |  |   |  |  |  |

Amesbury

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death unless it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.   |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HARRISON LINWOOD DENMYER</b>   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/14/83</b>  |  | 2b. HOUR<br><b>8:54P</b>   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Oct. 3 1918</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b>   |  | IF UNDER 1 YEAR MONTHS DAYS<br><b>YRS.</b>   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>                      |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GBMC 6701 N CHARLES ST</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Black &amp;</b>  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Cockeysville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>Decker 104 Old Padonia Rd., 21030</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Harrison Gilmore Denmyer</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Emma L. Heilmann</b>   |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No -</b>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>219-01-2251</b>   |  |  |  | 17. INFORMANT ADDRESS<br><b>Mary P. Denmyer, 104 Old Padonia Rd. 21030</b>  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY FAILURE</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOMYOPATHY</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45MN</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10/27</b> , 19 <b>83</b> , to <b>NOV 14, 1983</b> , that (I) (we) last saw the deceased alive on <b>NOV 14</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>B.C. Williamson, M.D.</b>   |  |  |  |   |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>11-14-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR B.C. WILLIAMSON</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>GBMC Towson, Maryland</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Cremation</b>  |  |  |  | 23b. DATE<br><b>11/16/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Catonsville Balto. Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. E. Lowell Lemmon</b>   |  |  |  |   |  | ADDRESS<br><b>21093</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |

MEDICAL CERTIFICATION





11 MAY 1947

HARRISON L. WOODMAN

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |                            |   |  |
|---|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Dominic DiCarlo</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/19/83</b> |   | 2b. HOUR<br><b>6:45 PM</b> |   |  |
| 3. SEX<br><b>male</b>   |  | 4. RACE<br><b>Cau</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 08 12</b>   |                            | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., M.D.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                            | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>White Marsh</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>10504 Vincent Rd. 21162</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Owner-Operator</b>   |                            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. CITY OR TOWN<br><b>Wicomico</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                            | 13d. STREET ADDRESS<br><b>100 Peach Tree Rd. 21842</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Constancio DiCarlo</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Constance DiDominicus</b>   |                            |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>1945-46</b>   |  | 17. INFORMANT<br><b>Catherine A. DiCarlo, wife</b>  |                            | Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CVA, left hemiplegia (CVA 11/8/83)</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Dehydration &amp; malnutrition</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Ca of right lung with metastasis to adrenal &amp; abd. &amp; lymph nodes</b><br>6 months<br>6 months |  |   |  |   |                            |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>ASCVD, Vas. insufficiency secondary to carotid artery stenosis</b>  |  |   |  |   |                            |   |  |
| 19a. DATE OF OPERATION<br><b>8/3/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>carotid artery stenosis</b>  |  | 20a. AUTOPSY?<br><b>no</b>  |                            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                            |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                            |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/19/83</b> to <b>11/19/83</b> , that (I) (we) last saw the deceased alive on <b>11/19/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |                            |   |  |
| 22b. SIGNATURE<br><b>Joseph D'Antonio</b>   |  |   |  | DEGREE<br><b>M.D.</b>   |                            | 22c. DATE SIGNED<br><b>11/19/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Joseph D'Antonio, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>7620 York Road; Towson, Md. 21204</b>  |                            |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(RECEIPT)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/22/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |                            | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Bruzdzinski Funeral Home</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1983</b>   |                            |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |   |  |   |                            |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHIEF

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXAMINER MUST EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. IF YOU ARE NOT A FUNERAL DIRECTOR, PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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FOR  
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REGISTRAR

ELLIS M. DIETER MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                      |  |  |   |  |   |  |  |
|---|----------------------|--|--|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ELLIS M DIETER</b>   |                      |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <b>19</b>          |   |  | 2b. HOUR <b>AM</b>  |  |  |
| 3. SEX <b>MALE</b>  | 4. RACE <b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH <b>04</b> DAY <b>28</b> YEAR <b>24</b> | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>59</b> YRS.  | IF UNDER 1 YR.<br>MONTHS <b></b> DAYS <b></b> | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD <b>NOV 30 1983</b>   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>   |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |
| 9. CITY OR TOWN OF DEATH <b>ROSEDALE</b>  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6006 HAMILTON AVE.</b> |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>LABORER</b>   |  |  |
| 10. CITY OR TOWN OF DEATH <b>ROSEDALE</b>   |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6006 HAMILTON AVE.</b> |   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>RAILROAD</b>   |  |  |
| 13a. STATE <b>MARYLAND</b>  |                      |  | 13b. COUNTY <b>BALTIMORE</b>   |   |  | 13c. CITY OR TOWN <b>ROSEDALE</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST <b>FRANK</b> MIDDLE <b></b> LAST <b>DIETER</b>   |                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>IDA</b> MIDDLE <b></b> LAST <b>SHEELINE</b>   |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>YES</b>  |                      |  | 16b. SOCIAL SECURITY NO. <b>217129616</b>  |   |  | 17. INFORMANT ADDRESS <b>OLLIE DIETER 6006 HAMILTON AVE.</b>  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>ARTERIOSCLEROTIC CARDIO-<br/>VASCULAR DISEASE</b><br>(c) <b></b>   |                      |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                      |  |  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |  |  |   |  |   |  |  |
| ACTUAL SIGNATURE <b>Paul F Guerin</b>   |                      |  | TITLE (SPECIFY) <b>DEPUTY</b>  |   |  | DATE SIGNED <b>11/30/83</b>   |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F GUERIN</b>  |                      |  | ADDRESS <b>1311 WESTERN RUN RD<br/>COCKEYSVILLE MD 21030</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>   |                      |  | 23b. DATE <b>12/3/83</b>   |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>GARDENS OF FAITH</b>  |  |  |
| 24. FUNERAL DIRECTOR <b>JJ Coal</b>   |                      |  | ADDRESS <b>1211 Chesapeake Ave.</b>  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>BALTO.</b> COUNTY <b>BALTO.</b> STATE <b>MD.</b>   |  |  |
| 25a. DATE REC'D. BY REGISTRAR <b>DEC 1 1983</b>   |                      |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Guerin</b>   |   |  |   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GAETANO DI MAGGIO</b>  |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>20</b> YEAR <b>83</b>   |  |   |   |
| 3. SEX<br><b>Male M</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>29</b> YEAR <b>90</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Italy</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTO. COUNTY GEN HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired Tailor</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. CITY OR TOWN <b>Baltimore</b> 13c. CITY OR TOWN <b>Randallstown</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |   |
| 14. FATHER'S NAME<br>FIRST <b>Carmelo</b> MIDDLE <b>DiMaggio</b> LAST <b>DiMaggio</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Carmela</b> MIDDLE <b>Bruno</b> LAST <b>Benno</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216-05-0616</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mr James DiMaggio 7812 Shepherd Ave</b>  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Arterio Sclerotic Cardiovasc. DISE.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Renal INSUFFICIENCY.</b> |  |  |  |   |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION<br><b>N/A</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-20-83</b> to <b>11-20-83</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-20-83</b> above (I) (we) (did) (did not) the body after death.  |  |  |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Leonard J Ruck Inc.</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-20-83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VUNDYALA V. REDDY</b>   |  |  |  | 22e. ADDRESS<br><b>BALTO. COUNTY GEN HOSPITAL<br/>RANDALLSTOWN, MD, 21133</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/23/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St Joseph Fullerton</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |   |
| 24. FUNERAL DIRECTOR<br>NAME <b>Leonard J Ruck Inc. Baltimore, Maryland</b> ADDRESS   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |   |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>EDITH ALICE DINNIS</b>                  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 27, 1983</b> |   |  | 2b. HOUR<br><b>8:55A</b> M  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>08 10 15</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>N. CAROLINA</b>                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>  |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>1820 WILHELM AVE.</b>                                   |  | 13f. ZIP CODE<br><b>21237</b>  |  | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GROVER C. THOMAS</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MAUD ROBINSON</b>                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217186240</b>  |  | 17. INFORMANT<br><b>ANITA KOEHLER</b>   |  | ADDRESS<br><b>1820 WILHELM AVE.</b>   |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b><br><b>1490</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>PHARYNGEAL CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **MICRONODULAR HEPATIC CIRRHOSIS**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 18, 1983</b> to <b>November 27, 1983</b> , that I (we) last saw the deceased alive on <b>NOVEMBER 27, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>Walter HEPNER</i> DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |  | 22c. DATE SIGNED<br><b>11/28/83</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>WALTER HEPNER M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>                              |  |  |  |

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>                   |  | 23b. DATE<br><b>11/30/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATL.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b> |  |
| 24. FUNERAL DIRECTOR<br><i>John Gach</i> ADDRESS<br><b>1211 Chesapeake Ave.</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 28 1983</b>       |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Linn</i>                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED  
JAN 10 1964  
U.S. DEPARTMENT OF AGRICULTURE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained in 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR<br>STATE<br>REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>WILHELMINE S. DODSON  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 24 83   |  |  |  | 2b. HOUR<br>2:30A  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 17, 1891  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>92 YRS                                      |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE, MD.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                   |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>GBMC-6701 N. CHARLES STREET |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOMEMAKER  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>MARYLAND  |  |  |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>BALTIMORE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis Sieburg  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Christina Morlok   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |  |  | 16b. SOCIAL SECURITY NO.<br>215-09-2701A  |  | 17. INFORMANT ADDRESS<br>Md. Masonic Homes, Cockeysville, Md. 21030            |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>7070<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEPSIS SHOCK</b><br>(c) <b>NECROTIC DECUBITUS</b> |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)<br><b>NECROTIC DECUBITUS, RENAL FAILURE</b>   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/15, 1983, to 11/24, 1983, that (I) (we) last saw the deceased alive on 11/24/1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, so state.)  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>J. Washington, M.D.  |  |  |  | DEGREE<br>M.D.  |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/24/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DR. J. WASHINGTON, M.D.   |  |  |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES STREET   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  |  |  | 23b. DATE<br>NOV. 28, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>OAKLAWN                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE, BALTIMORE CO., MD.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME, INC. BALTO., MD.  |  |  |  | ADDRESS<br>6500 YORK RD   |  | 25. DATE REC'D. BY REGISTRAR<br>DEC 01 1983                                    |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |  |  | REG. NO.   |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLAUDIUS C. DONOVAN</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>6</b> YEAR <b>83</b>                     |  | 2b. HOUR<br><b>M</b>   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>7</b> DAY <b>3</b> YEAR <b>04</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Idaho</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County</b> MD.                     |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>M Balto.</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>526 S. Chapelgate Lane</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Outfitter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>  |  |  |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>526 S. Chapelgate Lane 21229</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b></b> MIDDLE <b></b> LAST <b></b>   |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unkn.</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>181-03-5682</b>   |  | 17. INFORMANT<br><b>Mr. Howard Muhl</b>   |  | ADDRESS <b>908 Frederick Road Catonsville, Md.</b>                                   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4049</b><br>DUE TO, OR AS A CONSEQUENCE OF, (b) <b>Hypertensive Cardio Vascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF, (c) <b>A thrombo sclerosis Generalized</b><br>DUE TO, OR AS A CONSEQUENCE OF, (d) <b>Stroke left sided</b><br>PART 2. OTHER SIGNIFICANT CONDITION CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (e) <b>Perforated Viscerum</b> |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b><br><b>10 yrs</b><br><b>1974</b><br><b>1975</b> |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>8/4/83</b>   |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET <b>11/6/83</b>  |  | CITY OR TOWN   |  | COUNTY   |  | STATE  |  |
| 22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>10/6/83</b> to <b>11/6/83</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>10/6/83</b> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above. (If I <del>(was not)</del> did not view the body after death.  |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W.E. McGrath</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  |  |  | 22c. DATE SIGNED<br><b>11/10/83</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W.E. McGrath MD.</b>   |  | 22e. ADDRESS<br><b>1303 Frederick Rd Catonsville 21228 Md</b>  |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Removal</b>  |  | 23b. DATE<br><b>11/6/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN  |  | COUNTY   |  | STATE  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Anatomy Board</b>   |  |  |  | ADDRESS<br><b>Balto., Md.</b>   |  | 25a. DATE REC'D BY REGISTRAR<br><b>NOV 17 1983</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Myrtle C Doster</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov 4, 1983</b>                                       |  | 2b. HOUR<br>MIN.<br><b>6:06 P<sub>M</sub></b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 27, 1914</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>69</b>                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>St. Joseph Hospital</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT Home</b> | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   |   |  |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>PARKVILLE</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>2147 PITNEY ROAD 21234</b>                    |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>NORMAN B. DIGGS</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>CATHERINE J. HOFFMAN</b>                    |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>215-42-8706</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF,<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Massive Cerebral Vascular Accident</b><br><b>Massive cerebromacular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Malignant Hypertension</b><br><b>Malignant Hypertension</b> |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 4, 1983</b> to <b>NOV 4, 1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov 4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>George B. Albright, M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>11/4/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>GEORGE B. ALBRIGHT, II, M.D.</b>  |   | 22e. ADDRESS<br><b>10 WARREN RD., COCKEYSVILLE, MD</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>Nov. 7, 1983</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD CEM.</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO Maryland</b>      |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS CHAPEL OF CHIMES</b>   |   | ADDRESS<br><b>408K ROAD</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1983</b>                                | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Church</b>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





REG. NO.

|  |                                  |                                    |                               |                            |
|--|----------------------------------|------------------------------------|-------------------------------|----------------------------|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) | 23b. DATE                        | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION<br>CITY OR TOWN | Monroe County, STATE       |
| Burial                                       | Nov. 13'83                       | Zion Grove Cemetery                | Eagle Spring, N. C.           |                            |
| 24. FUNERAL DIRECTOR<br>NAME                 | LATNEY's Funeral Home<br>ADDRESS |                                    | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| 3831 Georgia Avenue, N.W.; Washington, DC    |                                  |                                    | NOV 17 1983                   | John J. Covert             |

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY  
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY  
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY  
OFFICE OF THE CHIEF OF THE BUREAU OF THE ARMY



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR OR TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |                                      |   |          |
|---|---|---|--|---|--------------------------------------|---|----------|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE KNOWN OF DEATH                                     |  | MONTH DAY YEAR  |                                      | 2b. HOUR  |          |
| 1. DECEASED NAME (TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |  | 2a. DATE KNOWN OF DEATH   |                                      | 2b. HOUR  |          |
| Paul Zackery Dowdy  |   |   |  | 11 6 1983   |                                      | M   |          |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS.                     | 2c. DATE PRONOUNCED DEAD  | 2d. HOUR |
| Male  | Black   | March 25, 1948  | 35 YRS.  | MONTHS DAYS HOURS MIN.  |                                      | 11 6 1983   | 5 A M    |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |          |
| North Carolina  | U.S.A.  |   |  |   | Baltimore County, MD.                |   |          |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |                                      | 12b. KIND OF BUSINESS OR INDUSTRY                                   |          |
|   | Southbound I-95   |   |  | Factory/Supervisor  |                                      |   |          |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |  |   |                                      |   |          |
| 13a. STATE  | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?   | 13e. STREET ADDRESS   |                                      |   |          |
| Pennsylvania  | Philadelphia  | Philadelphia  | NO <input type="checkbox"/>  | 548 Maylord Street  |                                      |   |          |
| 14. FATHER'S NAME   |   |   |  | 15. MOTHER'S MAIDEN NAME  |                                      |   |          |
| Charles Julius Dowdy  |   |   |  | Jessie Smith  |                                      |   |          |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.                                    |  | 17. INFORMANT   |                                      |   |          |
| Yes   |   | 243-80-2005   |  | 757 E. Main St. Lansdale, PA.<br>Jessie S. Dowdy (mother)                     |                                      |   |          |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |   |   |  |   |                                      |   |          |
| PART I DEATH WAS CAUSED BY:   |   |   |  |   |                                      |   |          |
| IMMEDIATE CAUSE (a) <u>Cranio cerebral trauma</u>   |   |   |  |   |                                      |   |          |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |   |                                      |   |          |
| (b)   |   |   |  |   |                                      |   |          |
| DUE TO, OR AS A CONSEQUENCE OF  |   |   |  |   |                                      |   |          |
| (c)   |   |   |  |   |                                      |   |          |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |   |   |  |   |                                      |   |          |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |  |   |                                      | 20. AUTOPSY?  |          |
|   |   |   |  |   |                                      | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |          |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 21b. TIME OF INJURY   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                      |   |          |
| 4:31 PM   |   | 11 6 1983   |  | Pedestrian struck by auto   |                                      |   |          |
| 21d. INJURY OCCURRED  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 21f. LOCATION   |                                      | 21g. CITY OR TOWN   |          |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |   | road  |  | I-95  |                                      | Baltimore, Md.  |          |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |   |                                      |   |          |
| ACTUAL SIGNATURE  |   | TITLE (SPECIFY)   |  | DATE SIGNED   |                                      |   |          |
| Thomas D. Smith   |   | M.D. Deputy Chief   |  | 11/6/83   |                                      |   |          |
| EXAMINER'S NAME (TYPE OR PRINT)   |   | ADDRESS   |  |   |                                      |   |          |
| Thomas D. Smith, M.D.   |   | 111 Penn St. Balto.   |  | MD.   |                                      |   |          |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |                                      | 23d. LOCATION CITY OR TOWN  |          |
| BURIAL  |   | Nov. 13 '83   |  | Zion Grove Cemetery   |                                      | Monroe County, STATE  |          |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR                               |  | 25b. REGISTRAR'S SIGNATURE  |                                      |   |          |
| LATNEY's Funeral Home   |   | NOV 17 1983   |  | John J. Connel  |                                      |   |          |
| 3831 Georgia Avenue, NW; Washington, DC   |   |   |  |   |                                      |   |          |

STATE

Missed

NOV 1 1963

RECEIVED

NOV 1 1963

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |  |   |   |   |   |   |  |
|---|--|---|--|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Doris M. DRNEC</b>                      |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 18 1983</b>             |   |   | 2b. HOUR P.<br><b>6:40 M</b>  |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11- 7- 1917</b>  |   | 6. AGE (IN YEARS (LAST BIRTHDAY))<br><b>66</b> YRS.                                 |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>                     |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                 |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Sq. Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Houswife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Homemaker</b> |  |
| 13a. STATE<br><b>Md.</b>  |  |   | 13b. COUNTY<br><b>Baltimore</b>                                      |   | 13c. CITY OR TOWN<br><b>Kingsville</b>                            |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Schmidt</b>                    |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Hoffman</b> |   |   | 16. ADDRESS<br><b>11905 Caspian Rd. Kingsville, Md. 21087</b>                       |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b> |  |   | 16b. SOCIAL SECURITY NO.<br><b>213-05-6654</b>                       |   | 17. INFORMANT<br><b>Mr. Frank J. Drnec, Kingsville, Md. 21087</b> |   |   |   |  |

|   |  |  |
|---|--|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Esophagus and Right Breast</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

**Acute Renal Failure, Anemia**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (if this hospital) attended the deceased from<br><b>November 14 83</b> to <b>November 18 83</b> , that <input checked="" type="checkbox"/> (we) lost<br>saw the deceased alive on <b>November 18 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, <input checked="" type="checkbox"/> (we) (did) (do) view the body after death. |  | 22b. SIGNATURE<br><b>Daniel M. Jannuzzi</b> DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/18/83</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Daniel M. Jannuzzi, M.D.</b>   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>   |  |  |  |   |  |

|   |  |                                |  |   |  |  |  |
|---|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>11-21-1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill Mem. Gar.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Middle River Balto. Md.</b> |  |
|---|--|--------------------------------|--|---|--|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn F.H.</b> |  | DATE REC'D. BY REGISTRAR<br><b>NOV 25 1983</b> |  | 25. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b> |  |
|---|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP

11 DE 1953

11 DE 1953

11 DE 1953

11-21-1953

11-21-1953



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |  |  | REG. NO.  |  |
|---|--|----------------------|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOHN J DRSEATA, SR.</b>  |  |                      |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 19 <input type="checkbox"/> M |  | 2b. HOUR <input type="checkbox"/> M  |  |   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>Aug 30, 1912</b>   |  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY MONTHS DAYS HOURS MIN <b>70 YRS.</b>   |  | 7. IF UNDER 1 YR. <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>   |  | 7c. DATE PRONOUNCED DEAD <b>NOV 13 1983</b> 19 <input type="checkbox"/> M |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  |                      |  | 9. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |   |  | 10. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County</b> MD.  |  |   |  |
| 11. CITY OR TOWN OF DEATH <b>Essex</b>  |  |                      |  | 12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Franklin Square Hospital</b> |  |   |  | 13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Safety Supervisor</b>   |  |   |  |
| 14. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>14a. STATE <b>Maryland</b>  |  |                      |  | 14b. CITY OR TOWN <b>Baltimore</b>   |  |   |  | 14c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 14d. STREET ADDRESS <b>9410 Dana Vista Rd 21236</b> |  |   |  |
| 15. FATHER'S NAME<br>FIRST MIDDLE LAST <b>Frank Drsata</b>  |  |                      |  | 16. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <b>Marie Hulla</b>   |  |   |  | 17. ADDRESS <b>Same As 13e</b>   |  |   |  |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 18b. SOCIAL SECURITY NO. <b>216-03-4671</b>  |  |   |  | 18c. INFORMANT <b>Mrs Mildred E Drsata</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CAROIO - 4292</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>UASCULAR DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                      |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                              |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.  |  |                      |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |   |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Paul F Guerin</b>   |  |                      |  | TITLE (SPECIFY) <b>DEPUTY</b> M.D. MEDICAL EXAMINER  |  |   |  | DATE SIGNED <b>NOV 14, 1983</b>  |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>PAUL F GUERIN</b>  |  |                      |  | ADDRESS <b>1311 WESTERN BLVD COCKEYSVILLE MD 21030</b>   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>11/17/83</b>  |  |   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>   |  |   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>   |  |                      |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 15 1983</b>   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE <b>John J. Guerin</b>  |  |                      |  |  |  |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |  | REG. NO.   |   |
|---|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>JOSEPH DUBECK</b>  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>WED. NOV. 30, 1983</b>                     |  | 2b. HOUR<br><b>11:00 AM</b>   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br><b>MARCH 14, 1919</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.                                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                  |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>TABCO TOWERS APTS. APT. 201</b><br><i>305 E. JOPPA RD.</i> |   |   | 12a. USUAL OCCUPATION<br>(OCCUPATION OR HOBBY (WORKING LIFE))<br><b>OFFICE CLERK</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTO. CITY</b>  |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br><b>MARYLAND</b>   |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>305 E. JOPPA RD. APT. 201 (21204)</b>           |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PHILIP DUBECK</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA SISCOVICK</b>  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   | 16b. SOCIAL SECURITY NO.   | 17. INFORMANT <i>UNT 2041</i> ADDRESS <b>NEW CARROLLTON, MD.</b><br><b>MRS. ADA KATCHER 7505 RIVERDALE RD.</b>  |   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiomyopathy</i><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 years</i>      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |
| 22a. I certify that (I) (as hospital) attended the deceased from <i>April</i> 19 <i>83</i> , to <i>Nov</i> 19 <i>83</i> , that (I) (we) lost<br>saw the deceased <i>Nov 21</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death. |  |   |   |  |  |   |
| 22b. SIGNATURE<br><i>John J. Terry</i><br>LUKE TERRY  |  |   |   | DEGREE   |  | 22c. DATE SIGNED<br><b>11/30/83</b>                                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |   | 22e. ADDRESS<br><i>9055 Chev. Dr.</i><br><b>ELLICOTT CITY, MD 21043</b>              |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |  | 23b. DATE<br><b>DEC. 4, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI ISRAEL CEM.</b>                        |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE, MD.</b> |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS.</b><br><b>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 6 1983</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Terry</i>                  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 28797

|  |  |  |   |                                      |  |
|--|--|--|---|--------------------------------------|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |   | 2b. HOUR                             |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | MONTH DAY YEAR   |   | MONTH DAY YEAR                       |  |
| ERNEST O. DUNNIGAN   |  | 11 21 83   |   | 4:40 AM                              |  |
| 3. SEX   | 4. RACE  | 5. DATE OF BIRTH   | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. IF UNDER 1 YEAR                   |  |
| MALE   | White  | MONTH DAY YEAR   | 77 YRS.   | MONTHS DAYS HOURS MIN.               |  |
| 5. DATE OF BIRTH   | 5 16 06  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |
|  |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |   | Baltimore County MD.                 |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY    |  |
| Maryland   | Baltimore Co. Gen. Hosp  | Policeman  |   | Baltimore City                       |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. CITY OR TOWN  | 13c. STREET ADDRESS / ZIP CODE   | 13d. INSIDE CITY LIMITS?  |                                      |  |
| Ind. Baltimore   | Reisterstown   | 502 Berrymans LA.  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                      |  |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |   |                                      |  |
| Howard Dunningan   | Emma Laura Knight  | No   |   |                                      |  |
| 16b. SOCIAL SECURITY NO.   | 17. INFORMANT  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |   |                                      |  |
| 215-32-4544  | Dorothy Gordon   | PART I. DEATH WAS CAUSED BY:   |   |                                      |  |
|  | Reisterstown, Ind  | IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST  |   |                                      |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |   |                                      |  |
|  |  | (b) CARDIAC ARRHYTHMIA   |   |                                      |  |
|  |  | DUE TO, OR AS A CONSEQUENCE OF   |   |                                      |  |
|  |  | (c) MYOCARDIAL INFARCTION  |   |                                      |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)                |  |  |   |                                      |  |
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |                                      |  |
|  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |                                      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |   |                                      |  |
|  | HOUR A.M. MONTH DAY YEAR   |  |   |                                      |  |
|  | P.M. 19  |  |   |                                      |  |
| 21d. INJURY OCCURRED   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    | 21f. LOCATION  |   |                                      |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | STREET CITY OR TOWN COUNTY STATE   |   |                                      |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-13-19-83 to 11-21-19-83, that (I) (we) lost                                  |  |  |   |                                      |  |
| saw the deceased alive on 11-21-19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated               |  |  |   |                                      |  |
| above, (I) (we) (did) (did not) view the body after death.   |  |  |   |                                      |  |
| 22b. SIGNATURE   | DEGREE   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | 22c. DATE SIGNED  |                                      |  |
|  | MD   |  | 11-21-83  |                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  | 22e. ADDRESS   |  |   |                                      |  |
| R. DEPESTRE  | BALTIMORE COUNTY GENERAL HOSP -  |  |   |                                      |  |
| 23a. BURIAL, CREMATION, REMOVAL  | 23b. DATE  | 23c. NAME OF CEMETERY OR CREMATORY   | 23d. LOCATION   | 23e. DATE REC'D. BY REGISTRAR        |  |
| BURIAL   | Nov. 23, 1983  | Holy Redeemer Cen  | Baltimore   | NOV 22 1983                          |  |
| 24. FUNERAL DIRECTOR   | 25a. REGISTRAR'S SIGNATURE   |  |   |                                      |  |
| He. Echhardt   | Owings Mills, Ind  |  |   |                                      |  |

35 55 85 30 1

MEDICAL CERTIFICATION

Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Page 1 of 1

1. The first part of the document is a list of names and addresses.

2. The second part of the document is a list of names and addresses.

3. The third part of the document is a list of names and addresses.

4. The fourth part of the document is a list of names and addresses.

5. The fifth part of the document is a list of names and addresses.

6. The sixth part of the document is a list of names and addresses.

7. The seventh part of the document is a list of names and addresses.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Julia V. Dunn                       |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 5 83 |   |  | 2b. HOUR<br>M<br>M  |  |   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 22 1910   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.        |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina                |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                                    |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Middle River                                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7 Everlasting Lane |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>River  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>7 Everlasting Lane 21220     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Walter Gerkins                   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Clara Williams   |  |   |  | 16. ADDRESS<br>7 Everlasting Lane Balto., MD. 21220 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-03-3713  |  | 17. INFORMANT<br>Albert D. Dunn   |  |   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4029  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Kyrie Baisio Ant. Scl. C.H. Disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

0

10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

*Diabetes m.*

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/1</i> 19 <i>82</i> to <i>11/5</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/3</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>R. Windsor</i>  |  |  |  | DEGREE<br>MD   |  | 22c. DATE SIGNED<br>11-7-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Roger Windsor, M.D.   |  |  |  | 22e. ADDRESS   |  |  |  |

|  |  |                        |  |   |  |  |  |
|--|--|------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                 |  | 23b. DATE<br>11/7/1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Meadowridge |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Dorsey Howard Maryland |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222 |  |                        |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1983       |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>                  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Analysis Howard Norway

DHMH - 17  
(VR A15 ME (5))  
20M 4/B2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28799  
REG. NO.

|   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST   |  | 20. DATE KNOWN OF DEATH   |  | MONTH  |  | DAY  |  | YEAR   |  | 2b. HOUR   |  |  |  |   |  |
| Gayberns  |  | H.   |  |  |  | Durant   |  | 11  |  | 6  |  | 19   |  | 83   |  | M  |  |  |  |   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)  |  | 7. IF UNDER 1 YR.   |  | 8. IF UNDER 24 HRS.  |  | 9. DATE PRONOUNCED DEAD  |  | 10. MONTH  |  | 11. DAY  |  | 12. YEAR   |  | 13. HOUR  |  |
| Male  |  | Black  |  | May 29, 1924   |  | 59 YRS.  |  | MONTHS  |  | DAYS   |  | HOURS  |  | MIN.   |  | 11   |  | 6  |  | 19  |  |
| 14. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 15. CITIZEN OF WHAT COUNTRY?                               |  | 16. MARRIED  |  | 17. NEVER MARRIED  |  | 18. WIDOWED   |  | 19. DIVORCED   |  | 20. BALTIMORE CITY OR COUNTY OF DEATH                            |  | 21. BALTIMORE CITY   |  | 22. COUNTY OF DEATH  |  | 23. BALTIMORE COUNTY   |  | 24. MD  |  |
| Lamar, S.C.   |  | U.S.A.   |  | MARRIED  |  | NEVER MARRIED  |  | WIDOWED   |  | DIVORCED   |  | BALTIMORE CITY   |  | BALTIMORE CITY   |  | BALTIMORE COUNTY   |  | BALTIMORE COUNTY   |  | BALTIMORE COUNTY  |  |
| 25. CITY OR TOWN OF DEATH   |  | 26. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 27. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 28. KIND OF BUSINESS OR INDUSTRY                                 |  | 29. CITY OR TOWN  |  | 30. STREET ADDRESS   |  | 31. CITY OR TOWN   |  | 32. STREET ADDRESS   |  | 33. CITY OR TOWN   |  | 34. STREET ADDRESS   |  | 35. CITY OR TOWN  |  |
| Baltimore Co.   |  | Southbound I-95  |  | Cook   |  | private  |  | Washington  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.                                      |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.                                       |  |
| 36. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 37. COUNTY   |  | 38. CITY OR TOWN   |  | 39. INSIDE CITY LIMITS?  |  | 40. STREET ADDRESS  |  | 41. CITY OR TOWN   |  | 42. STREET ADDRESS   |  | 43. CITY OR TOWN   |  | 44. STREET ADDRESS   |  | 45. CITY OR TOWN   |  | 46. STREET ADDRESS  |  |
| D.C.  |  | D.C.   |  | Washington   |  | YES  |  | 4810 Quarles St. N.E.   |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.                                      |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.                                       |  |
| 47. FATHER'S NAME   |  | 48. MOTHER'S MAIDEN NAME                                   |  | 49. WAS DECEASED EVER IN U.S. ARMED FORCES?                                  |  | 50. SOCIAL SECURITY NO.  |  | 51. INFORMANT   |  | 52. ADDRESS  |  | 53. CITY OR TOWN   |  | 54. STREET ADDRESS   |  | 55. CITY OR TOWN   |  | 56. STREET ADDRESS   |  | 57. CITY OR TOWN  |  |
| Robert  |  | Gladys   |  | yes  |  | 240-22-1791  |  | Ethel Durant  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.                                      |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.  |  | 4810 Quarles St. N.E.                                       |  |
| 58. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | 59. PART I DEATH WAS CAUSED BY:                            |  | 60. IMMEDIATE CAUSE (a)  |  | 61. DUE TO, OR AS A CONSEQUENCE OF                               |  | 62. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LOST. |  | 63. (b)  |  | 64. DUE TO, OR AS A CONSEQUENCE OF                               |  | 65. (c)  |  | 66. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  | 67. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                 |  | 68. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| 8147  |  | Multiple injuries  |  | Multiple injuries  |  | Multiple injuries  |  | Multiple injuries   |  | Multiple injuries  |  | Multiple injuries  |  | Multiple injuries  |  | Multiple injuries  |  | Multiple injuries  |  | Multiple injuries   |  |
| 69. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |  | 70. DATE OF OPERATION                                      |  | 71. CONDITION FOR WHICH OPERATION WAS PERFORMED?                             |  | 72. AUTOPSY?   |  | 73. YES   |  | 74. NO   |  | 75. YES  |  | 76. NO   |  | 77. YES  |  | 78. NO   |  | 79. YES   |  |
|   |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |
| 80. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH  |  | 81. TIME OF INJURY   |  | 82. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  | 83. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH |  | 84. TIME OF INJURY  |  | 85. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  | 86. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH |  | 87. TIME OF INJURY   |  | 88. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  | 89. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH |  | 90. TIME OF INJURY  |  |
| 4:3 PM  |  | 11 6 19 83   |  | Pedestrian struck by auto  |  | 4:3 PM   |  | 11 6 19 83  |  | Pedestrian struck by auto  |  | 4:3 PM   |  | 11 6 19 83   |  | Pedestrian struck by auto  |  | 4:3 PM   |  | 11 6 19 83  |  |
| 91. INJURY OCCURRED WHILE AT WORK   |  | 92. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 93. LOCATION   |  | 94. INJURY OCCURRED WHILE AT WORK                                |  | 95. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 96. LOCATION   |  | 97. INJURY OCCURRED WHILE AT WORK                                |  | 98. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  | 99. LOCATION   |  | 100. INJURY OCCURRED WHILE AT WORK                               |  | 101. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |  |
| NOT WHILE AT WORK   |  | road   |  | I-95   |  | NOT WHILE AT WORK  |  | road  |  | I-95   |  | NOT WHILE AT WORK  |  | road   |  | I-95   |  | NOT WHILE AT WORK  |  | road  |  |
| 102. I certify that I took charge of the remains described above, held on death resulted from   |  | 103. Autopsy   |  | 104. Inspection  |  | 105. Inquiry   |  | 106. and in my opinion  |  | 107. Autopsy   |  | 108. Inspection  |  | 109. Inquiry   |  | 110. and in my opinion   |  | 111. Autopsy   |  | 112. Inspection   |  |
| Natural cause   |  | Accident   |  | Suicide  |  | Homicide   |  | Undetermined manner   |  | Natural cause  |  | Accident   |  | Suicide  |  | Homicide   |  | Undetermined manner  |  | Natural cause   |  |
| 113. ACTUAL SIGNATURE   |  | 114. TITLE (SPECIFY)                                       |  | 115. DATE SIGNED   |  | 116. ACTUAL SIGNATURE  |  | 117. TITLE (SPECIFY)  |  | 118. DATE SIGNED   |  | 119. ACTUAL SIGNATURE  |  | 120. TITLE (SPECIFY)                                       |  | 121. DATE SIGNED   |  | 122. ACTUAL SIGNATURE  |  | 123. TITLE (SPECIFY)  |  |
| Thomas D. Smith, M.D.   |  | Deputy Chief   |  | 11/6   |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |



TO HOSPITAL, ATTENDING PHYSICIAN: The low requires that the death certificate be executed hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR Item 13c phone  
STATE REGISTRAR 11-22-83 cn

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

3 2 8 8 0 0

|  |  |   |   |  |  |
|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Henry Marion Eckhart</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 6, 1983</b>                                      |  | 2b. HOUR<br><b>3A</b> M  |
| 3 SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 30 1893</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS                               | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.            |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto., Co.</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4400 Briedenbaugh Lane</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security</b>             | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Glen L. Martin</b>                     |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. STREET ADDRESS / ZIP CODE<br><b>4400 Briedenbaugh Lane 21057</b>          |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Frederick Eckhart</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Amerien</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>yes</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>WW-1</b>   |   | 17. INFORMANT<br><b>Philip Eckhart Balto., Md. 21234</b>                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SHOCK</b><br><br><b>2390</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>NECROTIC TUMOR OF RECTUM</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, RIGHT INGUINAL HERNIA</b>  |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>8:45</b> , 19 <b>83</b> , to <b>11:16</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/5</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.            |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Walter R. Hepner</b>  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/8/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Hepner</b>   |  | 22e. ADDRESS<br><b>3313 Paper Mill Rd. Jacksonville, Md.</b>  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-9-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fork Methodist</b>                                     |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. F. Lassahn</b>   |  | 11750 Belair Rd.<br>Kingsville, Md. 21087   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Grier</b>   |

1902-1903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "1", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   | REG. NO.   |   |  |  |  |
|--|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>REBECCA S EDER</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>11</b> YEAR <b>83</b> 2b. HOUR <b>11 AM</b>                   |   |  |  |  |
| 3 SEX <b>FEMALE</b>  |  | 4 RACE <b>WHITE</b>   |   | 5 DATE OF BIRTH MONTH <b>1</b> DAY <b>4</b> YEAR <b>83</b>  |  | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. <b>10</b> DAYS <b>7</b>                       |  | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD</b>                    |  |  |  |
| 10 CITY OR TOWN OF DEATH <b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1774 STOKESLEY RD</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NONE</b>         |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN   |  |   |   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |   | 13e. STREET ADDRESS <b>1774 STOKESLEY RD</b>                             |  |  |
| 14 FATHER'S NAME FIRST <b>RICHARD</b> MIDDLE <b>W.</b> LAST <b>EDER</b>  |  |   |   |   | 15 MOTHER'S MAIDEN NAME FIRST <b>CHRISTINE</b> MIDDLE <b>J.</b> LAST <b>MAY</b>                        |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>-</b>   |   | 17 INFORMANT <b>Richard W. Eder</b>   |  | ADDRESS <b>7004 York Road Balto. MD 21212</b>                                     |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b><br><b>3350</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>WERDNIG HOFFMAN DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10 MO.</b>   |  |   |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MIDLITES</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/14/83</b> , 19 <b>83</b> , to <b>11/11/83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE <b>Maria Gumbinas M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   | 22c. DATE SIGNED <b>11/11/83</b>   |   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIA GUMBINAS, M.D.</b>  |  |   |   |   | 22e. ADDRESS <b>22 SO. GREENE ST. BALI. MD</b>   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  |   | 23b. DATE <b>11/14/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>   |   | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |  |
| 24 FUNERAL DIRECTOR <b>Duda-Ruck, Inc.</b> ADDRESS <b>79 22 Wise Avenue, Dundalk, MD 21222</b>   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b> |   |  |  |  |

RECEIVED

WHITE

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY

OPTIONAL COUNTY



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## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH 28802   |  |   |  | REG. NO.   |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Norman F. EICHORN   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 23, 1983                  |  |  |
| 3. SEX<br>M  | 4. RACE<br>W   | 5. DATE OF BIRTH MONTH DAY YEAR<br>10/22/11   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>72 YRS.                             |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.           |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>STEEL |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>STEEL   |
| 13a. STATE<br>MD   |  |   | 13b. COUNTY<br>BALTO   | 13c. CITY OR TOWN<br>ESSEX   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>MARTIN EICHORN  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>BLANCHE HEARD            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>21310 7925  | 17. INFORMANT ADDRESS<br>ROBT. EICHORN 8423 MARYLAND RD                |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiac Arrest<br>4149<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) Severe Coronary Artery Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 11a<br>Diabetes Mellitus   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from November 23, 1983, to November 23, 1983, that (I) (we) last saw the deceased alive on November 23, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br>Michael Heller   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11-23-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Michael Heller, M.D.  |  | 22e. ADDRESS<br>9000 Franklin Square Drive - 21237  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  | 23b. DATE<br>11/28/83  | 23c. NAME OF CEMETERY OR CREMATORY<br>GARDENS OF FAITH  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>BALTO MD                                  |  |
| 24. FUNERAL DIRECTOR NAME<br>J.G. CONNELLY   |  | ADDRESS<br>300 MACE   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 29 1983   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |  |  |  |
|---|--|---|---|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Virginia Frances Ellis</b>                    |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 7 83</b>   |   |  | 2b. HOUR<br>M<br><b>M</b>  |  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 2 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Colorado</b>                            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2017 Paulette Road Apt. 2</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress-Banquet Worker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  | 13e. STREET ADDRESS<br><b>21222</b>  |  |  |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13f. STREET ADDRESS<br><b>2017 Paulette Road Apt. 2</b>  |  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles F. Beaghan</b>                     |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Miller</b>   |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>       |  | 16b. SOCIAL SECURITY NO.<br><b>206-07-7266</b>  |   | 17. INFORMANT<br><b>2017 Paulette Road Apt. 2</b><br><b>William J. Ellis Balto., MD. 21222</b>  |  |  |  |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4274  
IMMEDIATE CAUSE (a) **Sudden Cardiac Death**  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Ventricular Fibrillation**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Instant**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.

MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-23</b> , 19 <b>83</b> , to <b>11-7</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10-28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-8-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |  |  |

|  |  |                                |  |  |  |  |  |
|--|--|--------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/11/1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc.</b><br><b>7922 Wise Avenue Dundalk, MD. 21222</b> |  |                                |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

2007-08-01 14:00:00

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>LEAH E. FAGAN  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 26 83 |   |  | 2b. HOUR<br>3:20 p.m.   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept. 10, 1898  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Penna.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Baito. Co. Gen. Hosp. |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife                   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>—             |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Ind. |  | 13b. COUNTY<br>Balto.  |   | 13c. CITY OR TOWN<br>Reisterstown   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>21136<br>107 Glyndon Dr. B2 |  |
| FATHER'S NAME<br>FIRST MIDDLE LAST<br>Christopher Entwistle   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Annie Sheigh   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No.                                       |  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>216-28-2310<br>820-00-4474   |  | 17. INFORMANT<br>ADDRESS<br>Robert Fagan 4803 Overton Ct.<br>Balto, MD 21229                    |  |  |  |

|   |  |   |  |
|---|--|---|--|
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PERITONITIS<br>5679<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) perforated viscus<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 hour<br>8 hr. |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  
ASCVD

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11:26, 1983, to 11:26, 1983, that (I) (we) last saw the deceased alive on 11:26, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Narayan  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/26/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>VIJAY NARAYEN M.D.  |  |  |  | 22e. ADDRESS<br>5401 OLD COURT ROAD 21133  |  |  |  |

|   |  |                            |  |  |  |  |  |
|---|--|----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Removal |  | 23b. DATE<br>Nov. 27, 1983 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>N. Barnesboro Cem. |  | 23d. LOCATION<br>CITY OR TOWN COUNTY<br>Barnesboro, Cambria Co., Pa. |  |
|---|--|----------------------------|--|--|--|--|--|

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR<br>NAME<br>A. E. Eckhardt |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1983 |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. Carver |  |
|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   | REG. NO.                         |   |
|--|--|---|---|---|----------------------------------|---|
| 1. FOR STATE REGISTRAR   |  |   | 1. DECEASED NAME (TYPE OR PRINT)          |   | 2a. DATE OF DEATH MONTH DAY YEAR |   |
|  |  |   | FIRST MIDDLE LAST<br>William Andrew Fagan |   | Nov. 25, 1983                    |   |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH MONTH DAY YEAR   |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |
| Male   |  | White   |   | April 29, 1901  |                                  | 82  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |
| Penna.   |  | U.S.A.  |   |   |                                  | Baltimore County  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                            |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |                                  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |
| Reisterstown   |  | 107 Glyndon Drive Apt. B2   |   | Self-emp Contractor   |                                  | Painter   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. INSIDE CITY LIMITS?  |   | 13c. STREET ADDRESS   |                                  |   |
| Md. Balto. Reisterstown  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 21136   |                                  |   |
| 14. FATHER'S NAME (TYPE OR PRINT)  |  | 15. MOTHER'S MAIDEN NAME  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |                                  | 16b. SOCIAL SECURITY NO.  |
| Charles Fagan  |  | Elma J. Raker   |   | Yes WW II   |                                  | 178-07-7061   |
| 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) |   | 19. DATE OF OPERATION   |                                  | 20a. AUTOPSY?   |
| 308 Leyton Road, Reisterstown, Maryland 21136  |  | Arteriosclerotic Cardiovascular disease   |   | None  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |
|  |  | 4292  |   |   |                                  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|  |  | DUE TO, OR AS A CONSEQUENCE OF  |   |   |                                  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |
|  |  | Generalized Atherosclerosis   |   |   |                                  |   |
|  |  | DUE TO, OR AS A CONSEQUENCE OF  |   |   |                                  |   |
|  |  | (c)   |   |   |                                  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |   |                                  |   |
| Parkinson's Disease  |  |   |   |   |                                  |   |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                                  | 22c. DATE SIGNED  |
|  |  | 11/11/83  |   |   |                                  | 11/26/83  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |                                  |   |
|  |  |   |   |   |                                  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 11, 1983, that (I) (we) last saw the deceased alive on 11/24/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |                                  |   |
| 22a. SIGNATURE   |  | 22b. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22c. ADDRESS  |                                  | 22d. DATE REC'D BY REGISTRAR  |
| Milton Schlenoff MD  |  | Milton Schlenoff MD   |   | 11969 Reisterstown Road   |                                  | NOV 28 1983   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                                  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |
| Removal  |  | Nov. 27, 1983   |   | N. Barnesboro Cem.  |                                  | Barnesboro, Cambria Cp. Pa.   |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS  |   | 25a. DATE REC'D BY REGISTRAR  |                                  | 25b. REGISTRAR'S SIGNATURE  |
| H. E. Schlenoff  |  | Owings Mills, Md 21117  |   | NOV 28 1983   |                                  | John J. Connel  |

BP



William ... ..

John ... ..

Tenn ... ..

John ... ..

John ... ..

John ... ..

John ... ..

100-1000

100-1000



John ... ..

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                           |   |  |
|---|--|--|---|---|---------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <span style="float: right;">FIRST MIDDLE LAST</span><br><b>William J. Farrell</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-8-83</b> |   | 2b. HOUR<br><b>7:35am</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 19, 1917</b>  |                           | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Montana</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                           | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Joseph Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Construction Engineer</b>  |                           | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY  |   | 13c. CITY OR TOWN<br><b>Baltimore</b>   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>6513 Harford Rd</b>   |  | 13f. CITY OR TOWN<br><b>21214</b>  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William L. Farrell</b>   |                           | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Agnes Foster</b>                            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>                                    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>ww 11 517-03-7290</b>   |   | 17. INFORMANT<br><b>Mrs Marie I Farrell</b>   |                           | ADDRESS<br><b>Same As 13e</b>   |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1629 Metastatic Carcinoma lungs</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma lungs</b>  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____  |  |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |   |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Arterio Sclerotic Cardiovascular Disease**

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11-2</b> , 19 <b>83</b> , to <b>11-8</b> , 19 <b>83</b> , that (X) (we) last saw the deceased alive on <b>11-8</b> , 19 <b>83</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (X) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Patricio</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/8/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Patricio K. PATRICIO</b>  |  | 22e. ADDRESS<br><b>7620 York Road Towson Md 21204</b>                  |  |  |  |  |  |

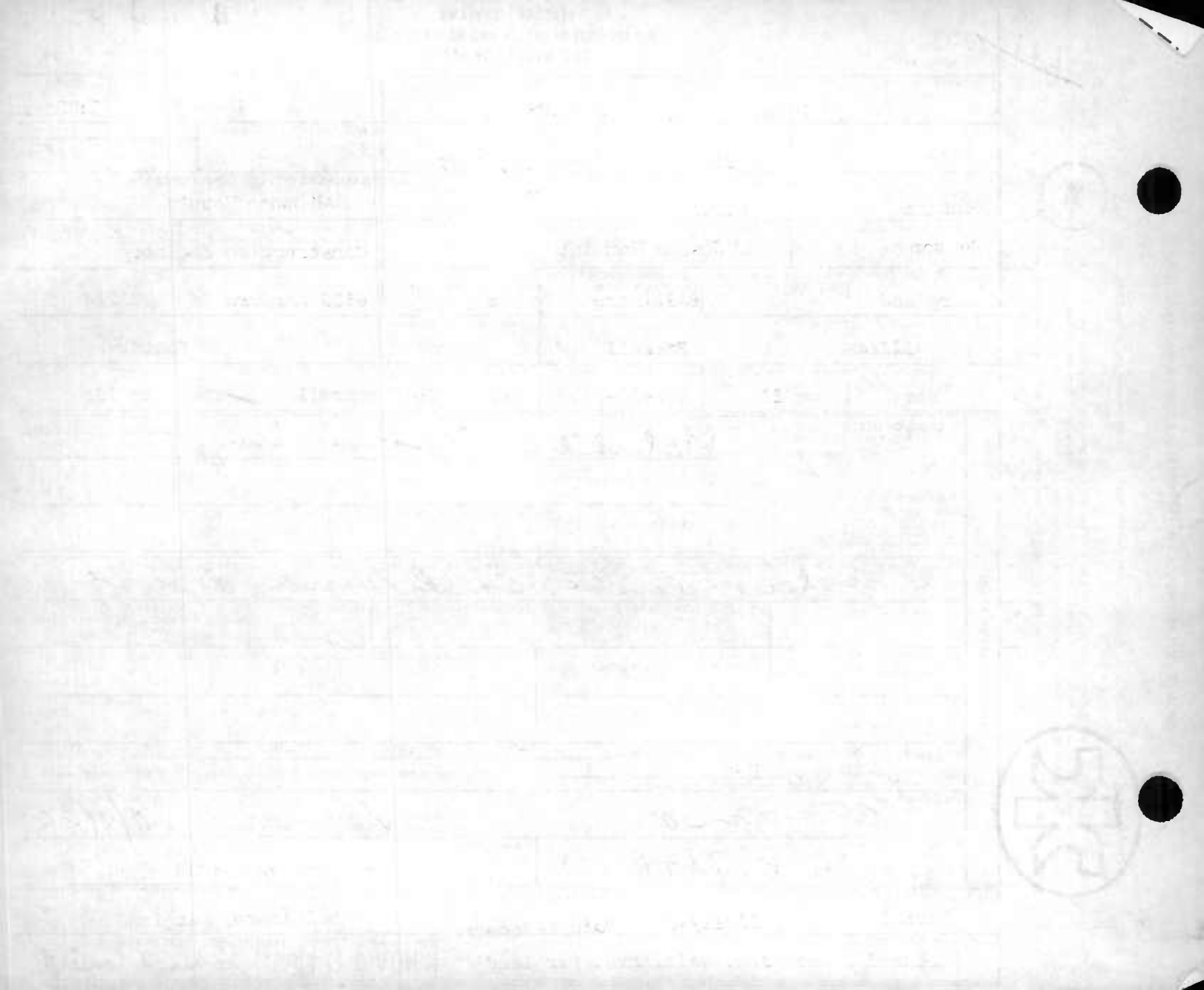
|  |  |                              |  |  |  |  |  |
|--|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                          |  | 23b. DATE<br><b>11/11/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1983</b>        |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>                      |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the undersigned, for, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Brady Elmore Ferguson</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>8</b> YEAR <b>83</b>  |  | 2b. HOUR <b>P</b><br><b>2:40</b> M   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>25</b> YEAR <b>1915</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>9101 Franklin Square Drive</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Expeditior</b>                                      |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |  |  | 13a. STREET ADDRESS<br><b>3448 Sollers Point Road</b>   |  |  |  |
| 13b. CITY OR TOWN<br><b>Dundalk</b>  |  |  |  | 13c. STREET ADDRESS<br><b>21222</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>Thomas</b> MIDDLE <b>W.</b> LAST <b>Ferguson</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lucy</b> MIDDLE <b>J.</b> LAST <b>Hambrick</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b>   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>WW II</b>   |  | 17. INFORMANT<br><b>Charlotte M. Ferguson-Balto., MD.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4960 Respiratory Failure</b><br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>&gt; 10 yrs.</b> |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>3-16</b> , 19 <b>83</b> , to <b>11-8</b> , 19 <b>83</b> , that (b) we last saw the deceased alive on <b>11-8</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Norris L. Horwitz MD.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  | 22c. DATE SIGNED<br><b>11-8-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Norris L. Horwitz, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>611 Park Avenue 21201</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  | 23b. DATE<br><b>11/14/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Nat.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Duda-Ruck, Inc.</b> ADDRESS <b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gifford</b>   |  |

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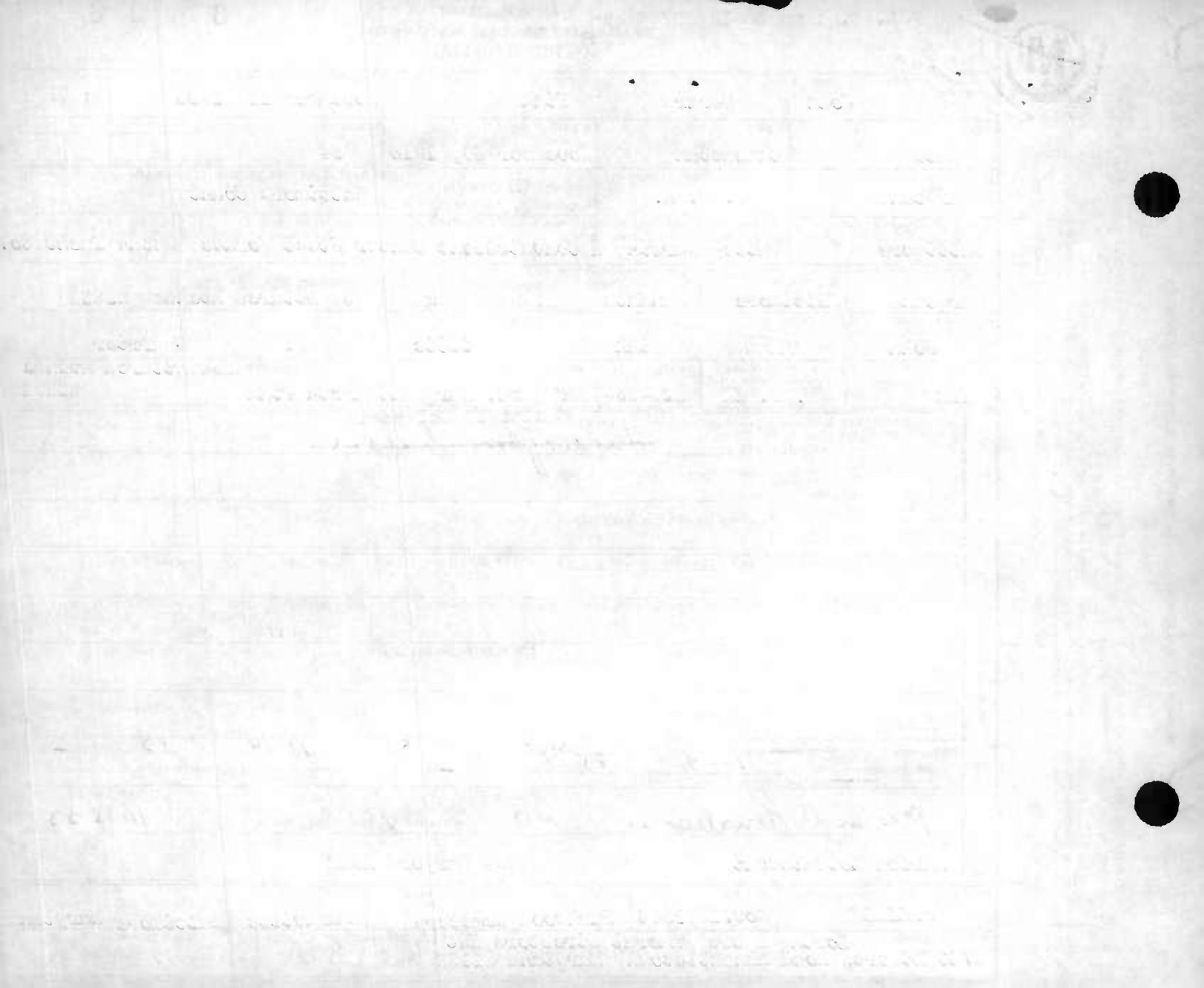
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of force.

## MEDICAL CERTIFICATION

| DECEASED NAME<br>(TYPE OR PRINT)   |        |      |  | 2a. DATE OF DEATH |      |  |     | 2b. HOUR |   |  |
|--|--------|------|--|-------------------|------|--|-----|----------|---|--|
| FIRST  | MIDDLE | LAST | MONTH  | DAY               | YEAR | MONTH  | DAY | YEAR     | MIN.  |  |
| John   | Gerard | Fink | November   | 14                | 1983 |  |     |          | 4:27P   |  |
| 3. SEX   |        |      | 4. RACE  |                   |      | 5. DATE OF BIRTH   |     |          | 6. AGE (IN YEARS (LAST BIRTHDAY))                                   |  |
| Male   |        |      | Caucasian  |                   |      | November 30, 1918  |     |          | 64 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |        |      | 7b. CITIZEN OF WHAT COUNTRY?   |                   |      | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |     |          | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Maryland   |        |      | U. S. A.   |                   |      |  |     |          | Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH  |        |      | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)        |                   |      | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)   |     |          | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Baltimore  |        |      | Valley Nursing & Convalescent Center   |                   |      | Steel Worker   |     |          | Owens Yacht Co.   |  |
| 13a. STATE   |        |      | 13b. COUNTY  |                   |      | 13c. CITY OR TOWN  |     |          | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |        |      | Baltimore  |                   |      | Dundalk  |     |          | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME  |        |      | 15. MOTHER'S MAIDEN NAME   |                   |      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |     |          | 16b. SOCIAL SECURITY NO.  |  |
| John Adam Fink   |        |      | Millie B. Spurrier   |                   |      | YES  |     |          | 218-05-4886   |  |
| 17. INFORMANT  |        |      | ADDRESS  |                   |      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Huntington's disease</u><br>3400<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Multiple Sclerosis</u> |     |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| Mrs. Mary Elizabeth Fink   |        |      | 854 Mildred Avenue 21222   |                   |      |  |     |          |   |  |
| 19a. DATE OF OPERATION   |        |      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |      | 20a. AUTOPSY?  |     |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |        |      |  |                   |      | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |     |          | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |        |      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   |      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |     |          |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |        |      | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                   |      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |     |          |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 11-9</u> 19 <u>83</u> , to <u>11-14</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11-9</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |        |      | 22b. SIGNATURE<br><u>Marion C. Kolwalewski</u> MD<br>22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Marion Kolwalewski |                   |      | 22c. DATE SIGNED<br>11-15-83   |     |          |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |        |      | 23b. DATE  |                   |      | 23c. NAME OF CEMETERY OR CREMATORY   |     |          | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| BURIAL   |        |      | Nov. 18, 1983  |                   |      | Parkwood Cemetery  |     |          | Parkville Baltimore Maryland  |  |
| 24. FUNERAL DIRECTOR   |        |      | 25. DATE REC'D. BY REGISTRAR   |                   |      | 26. REGISTRAR'S SIGNATURE  |     |          |   |  |
| Loring Byers Funeral Directors, INC<br>8728 Liberty Road Randallstown, Maryland 21133  |        |      | NOV 18 1983  |                   |      | John J. Connel   |     |          |   |  |







FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |  |
|---|--|--|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH FISCHER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/21/83</b>                 |  |  | 2b. HOUR<br><b>9:45P<sub>M</sub></b>  |   |  |
| 3. SEX<br><b>F.</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6/12/18</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65 yr.</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN, COUNTRY)<br><b>Baltimore</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>MD.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><b>MD.</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                 |   | 13e. STREET ADDRESS / ZIP CODE<br><b>31312</b><br><b>116 Purbeck Rd.</b>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Stanislaus</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna M. Butella</b>  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT<br>ADDRESS<br><b>31330</b><br><b>Thomas Hughes Fred St.</b>  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYPOTENSION</b><br><b>5990</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEPTIC SHOCK</b><br>(c) <b>UTI SEEDING TO BLOOD</b>                                    |  |  |  |  |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>PT. ALSO HAD HYPERGLYCEMIA SECONDARY TO DM</b>   |  |  |  |  |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/19</b> , 19 <b>82</b> , to <b>11/21</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/21</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |
| 22b. SIGNATURE<br><b>P. Siemer MD</b>   |  |  | DEGREE   |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. P. SIEMER</b>   |  |  | 22e. ADDRESS<br><b>GBMC</b>  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(DATE)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11/25/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Burial Valley</b>                     |   | 23d. LOCATION<br>CITY OR TOWN<br><b>Cockeysville, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Charles L. Siemer</b>  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1983</b>                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>George A. ...</b>                             |   |   |  |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BALTIMORE COUNTY

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TOWSON

HYATTSPRING

SEPTIC TANK

171 SEPTIC TANK

171 ALD. H. HYATTSPRING SEPTIC TANK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 shall be retained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |   |  |
|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Ida N/M/N Fitz</b>   |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-16-83</b>  |  |  |  | 2b. HOUR<br><b>5-25 AM</b>   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 4, 1898</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>85</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.                      |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Russia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD</b>                   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. General Hosp.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                 |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  |  |  | 13b. COUNTY<br><b>St. Mary's</b>  |  | 13c. CITY OR TOWN<br><b>Mechanicville</b>  |  | 13d. INSIDE CITY LIMITS?<br>NO <input checked="" type="checkbox"/>                   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>General Delivery 20659</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Bothe</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Amelia Kramer</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>220-48-3642</b>  |  | 17. INFORMANT (SON) New Brunswick, N.J.<br><b>Richard Fitz, 5 Ellen Street</b>       |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest 20</b><br><b>4275</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>to Cerebro-Vascular accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>underlying cause lost</b>         |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)  |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-28-1983</b> to <b>11-16-1983</b> , that (I) (we) lost<br>saw the deceased alive on <b>11-16-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>R-M. Shah m.d</b>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>11-16-83</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R-M. SHAH m.d</b>   |  |  |  | 22e. ADDRESS<br><b>5310 Old Court Rd., Randallstown, Md.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>11-19-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Trinity Mem. Gdns.</b>                      |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Waldorf, Charles, Md.</b>           |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Huntt Funeral Home, Waldorf, Maryland</b>  |  |  |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1983</b>  |  | 25. REGISTRAR'S SIGNATURE<br><b>John J. Gault</b>                                    |  |  |  |   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |   |  |   |   |  |
|--|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William <sup>MIDDLE</sup> Lawrence <sup>LAST</sup> FITZGERALD Jr.               |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 8, 1983   |   | 2b. HOUR<br>12:14pm   |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>9 19 19   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>64<br>YRS                 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD. |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Electrician   |   | 12b. KIND OF BUSINESS OR INDUSTRY                            |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland |  |   | 13c. CITY OR TOWN<br>Baltimore   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>William <sup>MIDDLE</sup> Lawrence <sup>LAST</sup> Fitzgerald Sr.                                 |  |   | 15. MOTHER'S MAIDEN NAME<br>Eva <sup>FIRST</sup> Grill <sup>MIDDLE</sup> Grill <sup>LAST</sup> |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>W.D. 2  |  | 17. INFORMANT<br>ADDRESS<br>Estella E. Fitzgerald 924 Rosedale Ave.   |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4140  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b) Atherosclerosis Heart Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 74, 1974, to Nov 1983, that (I) (we) last saw the deceased alive on 10/2/83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Robert Lyden, M.D.   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/9/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |   |  |

|  |  |                       |  |   |  |   |  |
|--|--|-----------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                   |  | 23b. DATE<br>11-11-83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Oak Lawn Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Eastwood, Balto. Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>Charles S. Zeiler & Son Inc. 901 S. Conkling St. |  |                       |  | DATE REC'D. BY REGISTRAR<br>NOV 9 1983                  |  | REGISTRAR'S SIGNATURE<br>J. J. Conkling                                 |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |                                       |  |   |  |  |  |
|--|--|---|--|---|---------------------------------------|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John J. FITZPATRICK</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 20 83</b>             |   |                                       | 2b. HOUR<br><b>10:00 P M</b>   |   |  |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 23 04</b>  |                                       | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS                                       |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTH PLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                       | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                    |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |  |   |                                       | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Tile Setter</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Contractor</b>             |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> |  |   | 13b. COUNTY<br><b>Baltimore</b>                                      |   | 13c. CITY OR TOWN<br><b>Baltimore</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>8838 Roland Ave.-Apt. 1402-21211</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Fitzpatrick</b>   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lena Unknown</b> |   |                                       | 16. ADDRESS<br><b>Parkton, Md.</b>   |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-03-5124</b>  |  | 17. INFORMANT<br><b>Norman Stifler -10 Quail Hill Ct. 21120</b>   |                                       |  |   |  |  |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4920</b> |  | IMMEDIATE CAUSE (a) <b>Respiratory failure</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.                          |  | (b) <b>chronic obstructive pulmonary</b>       |  | <b>years</b>                                 |  |
|   |  | (c) <b>disease; emphysema</b>                  |  | <b>years</b>                                 |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:  
**Congestive heart failure**

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |

22a. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that (I) (we) last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

|   |  |  |  |                                     |  |
|---|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE<br><b>S. m. de la Monte</b>                        |  | DEGREE<br><b>MD</b>                              |  | 22c. DATE SIGNED<br><b>11-20-83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>S. m. de la Monte</b> |  | 22e. ADDRESS<br><b>7620 York Rd. Towson, Md.</b> |  |                                     |  |

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>                                      |  | 23b. DATE<br><b>11-23-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Balto. Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. ...</b>                         |  |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked as item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.



214-03-3176 Norman Miller - 10 Quail Hill Ct. 21130  
 Frank Richardson  
 2696 Roland Ave. - Apt. 1403-21231  
 U.S.A.

214-03-3176 Norman Miller - 10 Quail Hill Ct. 21130  
 Frank Richardson  
 2696 Roland Ave. - Apt. 1403-21231  
 U.S.A.

214-03-3176 Norman Miller - 10 Quail Hill Ct. 21130  
 Frank Richardson  
 2696 Roland Ave. - Apt. 1403-21231  
 U.S.A.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 8 8 1 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |   |  |
|--|--|--|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>MARY CELERA FLEMING</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-11-83</b>                 |   |  | 2b. HOUR<br>MIN.<br><b>10:00 A.M.</b>  |   |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>1-6-1912</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto. Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital Production Lab</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Armco Steel</b>   |  |
| 13a. STATE<br><b>Md.</b>   |  | 13b. COUNTY<br><input checked="" type="checkbox"/>   |  | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   | 13e. STREET ADDRESS<br><b>5566 Cedonia Avenue-21205</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Ludwig</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Ludwig</b>   |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-01-6099</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Joseph W. Fleming - 5566 Cedonia Ave. - 21206</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>0389 Infected decub's two ulcer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Sepsis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>few days</b>  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |  |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK<br>NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-8-83</b> to <b>11-11-83</b> , that (I) (we) last saw the deceased alive on <b>11-11-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Soondul Hong</b>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-11-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOONDUL HONG</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11-15-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>John C. Miller Inc-6415 Belair Rd.-21206</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John C. Miller</b>   |  |

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to sign.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |  |   |   |  |
|---|--|---|--|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 28814  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Lena Mae B. FLETCHER</b>  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 30, 1983</b>                      |  |   | 2b. HOUR<br><b>7:56 P.M.</b>                              |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>11-15-1903</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>80</b>                                  |   | IF UNDER 1 YEAR MONTHS DAYS<br># UNDER 24 HRS. HOURS MIN. |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>Peel</b> 13c. CITY OR TOWN <b>Perry Hall</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE <b>8901 Carlisle Ave. 21702</b>  |   |  |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Calvin D. Bundick</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Saddie Richardson</b>  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>228-48-5443</b>  |   | 17. INFORMANT ADDRESS<br><b>Calvin Fletcher 8901 Carlisle Ave. Perry Hall, Md.</b> |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4292</b> IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Complications from severe arteriosclerotic cardiovascular disease</b><br>(c) _____   |  |   |  |   |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |   |  |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |   |  |
| 22a. I certify that (if (this hospital) attended the deceased from <b>Nov. 25</b> , 19 <b>83</b> , to <b>Nov. 30</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 30</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death. |  |   |  |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Augustus Ohemeng</b>   |  |   |  | DEGREE  |   |  |   | 22c. DATE SIGNED<br><b>11/30/83</b>                       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Augustus Ohemeng, MD</b>  |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Dr., 21237</b>  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12-4-1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Downing Lane</b>   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Dele Hall Accorack, R.</b>           |   |   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Wick</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 09 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canick</b>                                |   |   |  |

Form 100-10 (Rev. 1-1-60)

1. Name of the person or organization: [illegible]

2. Address: [illegible]

3. City: [illegible] State: [illegible] Zip: [illegible]

4. Date: [illegible]

5. Signature: [illegible]

6. Title: [illegible]

7. Organization: [illegible]

8. Purpose of the trip: [illegible]

9. Estimated cost: [illegible]

10. Other information: [illegible]

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 2-8815  |  |   |   |
|---|--|---|--|--|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) <b>Buelah N Flohr</b>  |  |   |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>20</b> YEAR <b>83</b> 2b. HOUR <b>5:00 PM</b>   |  |   |   |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH <b>2</b> DAY <b>20</b> YEAR <b>1892</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Catonsville BALTO MD</b>  |   |
| 10. CITY OR TOWN OF DEATH <b>Catonsville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Meredian Catonsville Nursing Center</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |   |
| 13a. STATE <b>Md</b>  |  | 13b. COUNTY <b>Baltimore</b>  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME FIRST <b>Richard</b> MIDDLE <b>Williams</b> LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Augusta</b> MIDDLE <b>Hale</b> LAST   |  | 13e. STREET ADDRESS <b>4 Locust Drive 21228</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO. <b>220 24 7191</b>   |  | 17. INFORMANT ADDRESS <b>Corinne Pope - Catonsville, Md.</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Lower G.I. Bleed</b><br><b>1539</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lower 7 lower bowel ulcer</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>ulcer</b>     |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Da.</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Atherosclerosis Cardiovascular disease</b>  |  |   |  |  |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/13/83</b> 19 <b>83</b> , to <b>11/20</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/13/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |   |
| 22b. SIGNATURE <b>C. M. Ratliff Jr.</b> DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  | 22c. DATE SIGNED <b>11/20/83</b>   |  |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CLIFF RATLIFF JR.</b>  |  |   |  | 22e. ADDRESS <b>5772 Westview Mall</b>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (IF CREM) <b>BURIAL</b>   |  | 23b. DATE <b>11-22-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mariettaville Howard Md.</b>   |   |
| 24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykeville, Md.</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 21 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |   |  |   |   |  |
|---|--|--|---|---|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>M JANE FOGLE</b>   |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>27</b> YEAR <b>83</b>                         |   |   | 2b. HOUR<br><b>9:44p<sub>M</sub></b>   |   |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>white</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>09</b> DAY <b>8</b> YEAR <b>31</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>52</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO COUNTY</b> MD.  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>teletype oper.</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Armco Steel Co.</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>M</b>   |  |  | 13b. COUNTY<br><b>BALTO</b>   |   | 13c. CITY OR TOWN<br><b>BALTO</b>                             |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST <b>August</b> MIDDLE <b>William</b> LAST <b>Rosenberger</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Catherine</b> LAST <b>Garrett</b> |   |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>no</b>   |   |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>215-30-1554</b>  |  |  | 17. INFORMANT ADDRESS<br><b>John R. Fogle, Jr. 1861 Loch Shiel Rd. Bal. Md.</b>           |   |   |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA - XXXXXXXXXXXX</b><br><b>3580</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ASPIRATION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>MYASTHENIA GRAVIS</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |   |  |   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |  |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                         |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                     |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |   |   |  |
| 22b. SIGNATURE<br><b>Maurice B Furlong Jr MD</b>  |  |  | DEGREE<br><b>MD</b>   |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-28/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MAURICE B FURLONG Jr MD</b>   |  |  | 22e. ADDRESS<br><b>St Joseph Hospital</b>   |   |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>Nov.30,1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Balto. County, Md.</b>               |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home</b>  |  |  | ADDRESS<br><b>6500 York Rd. Bal. Md.</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 6 1 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |

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|                    |       |    |                         |    |      |
|--------------------|-------|----|-------------------------|----|------|
| NAME               | FOGLE | 11 | 27                      | 85 | 3-11 |
| SEX                | WHITE | 21 | 85                      | 21 |      |
| AGE                | USA   | XX | BALTO COUNTY            |    |      |
| ST JOSEPH HOSPITAL |       |    |                         |    |      |
| TOWSON             |       |    |                         |    |      |
| BALTO              | BALTO | XX | 1561 LOCH SHIEL RD 2127 |    |      |
| ALLIANCE           | JOHN  |    |                         |    |      |

ACUTE PULMONARY EDEMA - XXXXXXXX  
ASPIRATION  
HYSTHENIA GRAVIS



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |  |   | REG. NO.  |  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Allie Louise FORMAN</b>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 10, 1983</b> |  |  | 2b. HOUR<br><b>12:07pm</b>   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 18 1940</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>43</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Waitress</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Essex Inn</b>  |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Essex</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>406 Torner Road 21221</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Russell Feathers</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Verdia Blanche Anderson</b>   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>267-56-8523</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Robert L. Forman 406 Torner Road Balto, MD. 21221</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>3453</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Status Epilepticus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 8, 1983</b> to <b>November 10, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 10, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death. |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><br>DEGREE <b>M.D.</b>   |  |  |  |   |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-10-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ramona Robinson, M.D.</b>  |  |  |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>11/12/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Ht. Of Mary</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dundalk Baltimore MD.</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>   |  |  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br>   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 8 8 1 8

1- FOR  
STATE  
REGISTRAR

Julius Fowler

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Julius</i> <i>Fowler</i> |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>11</i> <i>30</i> <i>83</i>  |  | 2b. HOUR<br><i>8</i> <i>AM</i>  |   |
| 3. SEX<br><i>Male</i>   | 4. RACE<br><i>White</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>May</i> <i>18</i> , <i>1909</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>74</i><br>YRS. MONTHS DAYS HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Baltimore, Md.</i>                      | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.         |   |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>East Point Nursing Home</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Fed. Protection</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>GSA</i> |
| 13a. STATE<br><i>Md.</i>  |   | 13b. CITY OR TOWN<br><i>Baltimore</i>   | 13c. STREET ADDRESS / ZIP CODE<br><i>122 N. Potomac Street 21224</i>                       |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>William H. Fowler, Sr.</i>                 |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Sophia Hilgeman</i>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>Yes</i>      |   | 16b. SOCIAL SECURITY NO.<br><i>1929-1935 213-07-7371</i>  |  | 17. INFORMANT<br><i>Baltimore, Md. 21224. St. 115 N. Potomac</i>            |   |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

1629

IMMEDIATE CAUSE (a)

*Neurotoxic cocaine lung*

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

*2 hr.*

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0

MEDICAL CERTIFICATION

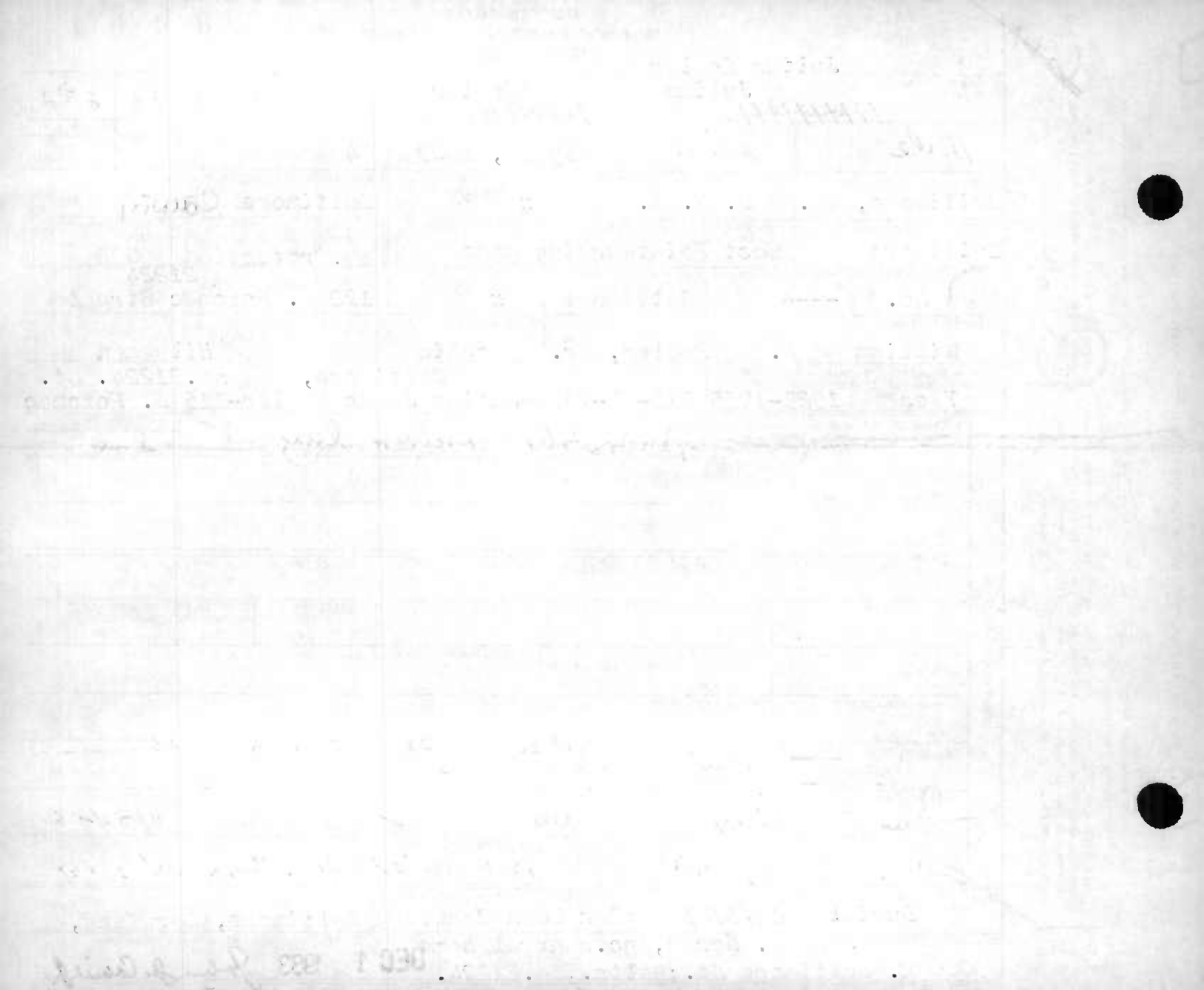
|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/26</i> , 19 <i>83</i> , to <i>11/30</i> , 19 <i>83</i> , that (I) (we) lost<br>saw the deceased alive on <i>11/26</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>John A. Moran</i>  |  | DEGREE<br><i>MD</i>  |  | 22c. DATE SIGNED<br><i>11/30/83</i>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>LOUIS D. GUSEN</i>  |  | 22e. ADDRESS<br><i>1012 W. NPT. Rd, Balto Md 21224</i>                 |  |  |   |

|   |                             |  |  |
|---|-----------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>           | 23b. DATE<br><i>12/3/83</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Baltimore, Maryland</i> |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>John A. Moran, Inc. Funeral Home</i> |                             | 25. DATE REC'D. BY REGISTRAR<br><i>DEC 1 1983</i>              | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canfield</i>                    |
| 3000 E. Baltimore St., Balto., Md. 21224.                               |                             |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. For page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. FOR STATE REGISTRAR   |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | 2a. DATE OF DEATH   |  | 2b. HOUR   |   |
| Joseph Edward Frank  |   | November 27, 1983   |  | 4:45 p M   |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                | 7. IF UNDER 1 YEAR   |   |
| MALE   | WHITE   | 10/14/1918  | 65   | MONTHS DAYS HOURS MIN.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |   |
| MARYLAND   | U.S.A.  |   | Baltimore County MD.   |  |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY  |   |
| ROSSVILLE  | FRANKLIN SQUARE HOSPITAL  |   | AUTO MAKER   | AUTOMOBILE   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS / ZIP CODE                                   |  |   |
| MARYLAND   | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 2817 ROSELAWN AVENUE 21214                                       |  |   |
| 14. FATHER'S NAME  | 15. MOTHER'S MAIDEN NAME  |   |  |  |   |
| JOHN   | MARY JOSEPHINE SANDEBECK  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)  | 17. INFORMANT   |  |  |   |
| YES  | WW 11   | CECILIA M. FRANK BALTIMORE MARYLAND   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:   |   |   |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 4100 IMMEDIATE CAUSE (a)   |   |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |  |   |
| Coronary Artery Disease  |   |   |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF   |   |   |  |  |   |
| Prior Myocardial infarctions   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |   |
|  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |
|  |   | P.M. 19   |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |
|  |   |   |  |  |   |
| 22a. I certify that (I (this hospital) attended the deceased from Nov 27, 1983, to Nov 27, 1983, that (we) last saw the deceased alive on Nov 27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.) |   |   |  |  |   |
| 22b. SIGNATURE   |   |   |  | 22c. DATE SIGNED   |   |
| Michael Heller, M.D.   |   |   |  | 11-27-83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   |  | 22e. ADDRESS   |   |
| Michael Heller, M.D.   |   |   |  | 9000 Franklin Square Dr. 21237   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |
| BURIAL   |   | 11/30/1983  |  | Most Holy Redeemer   |   |
|  |   |   |  | BALTIMORE MARYLAND   |   |
| 24. FUNERAL DIRECTOR<br>NAME   |   | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |   |
| Dignity Funeral Homes, Inc.  |   | 7110 Belair Road<br>Baltimore, Md.  |  | NOV 28 1983  |   |
|  |   |   |  | 25b. REGISTRAR'S SIGNATURE   |   |
|  |   |   |  | John J. Conner   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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|--|--|--|--|--|--|--|
| <div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>13</div> <div>14</div> <div>15</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div> <div>26</div> <div>27</div> <div>28</div> <div>29</div> <div>30</div> <div>31</div> <div>32</div> <div>33</div> <div>34</div> <div>35</div> <div>36</div> <div>37</div> <div>38</div> <div>39</div> <div>40</div> <div>41</div> <div>42</div> <div>43</div> <div>44</div> <div>45</div> <div>46</div> <div>47</div> <div>48</div> <div>49</div> <div>50</div> <div>51</div> <div>52</div> <div>53</div> <div>54</div> <div>55</div> <div>56</div> <div>57</div> <div>58</div> <div>59</div> <div>60</div> <div>61</div> <div>62</div> <div>63</div> <div>64</div> <div>65</div> <div>66</div> <div>67</div> <div>68</div> <div>69</div> <div>70</div> <div>71</div> <div>72</div> <div>73</div> <div>74</div> <div>75</div> <div>76</div> <div>77</div> <div>78</div> <div>79</div> <div>80</div> <div>81</div> <div>82</div> <div>83</div> <div>84</div> <div>85</div> <div>86</div> <div>87</div> <div>88</div> <div>89</div> <div>90</div> <div>91</div> <div>92</div> <div>93</div> <div>94</div> <div>95</div> <div>96</div> <div>97</div> <div>98</div> <div>99</div> <div>100</div> </div> |  |  |  |  |  |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 28820   |  |   |  |
|--|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>LOUIS HENRY FREDERICK JR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>11 26 83   |  |   |  | 2b. HOUR<br>30P  |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 10 18   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS  |  | 7b. IF UNDER 24 HRS<br>HOURS MIN.                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto, Md.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.                                  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>(GBMC)<br>6701 NORTH CHARLES STREET |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Retired from Bethlehem Steel |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                   |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |  | 13c. CITY OR TOWN<br>Reisterstown  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>          |  | 13e. STREET ADDRESS / ZIP CODE<br>5930 Glen Falls Rd. 21136  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Louis H. Frederick Sr.   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Margaret Peterson   |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>Yes   |  | 16b. SOCIAL SECURITY NO.<br>WW 2  |  | 17. INFORMANT ADDRESS<br>Mrs. Irene B. Frederick Reisterstown  |  |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>G I BLEEDING</u><br>1539<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>COLON CARCINOMA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>DO NOT KNOW</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH        |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DO NOT KNOW</u>  |  |   |  |  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>          |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-26-19-83</u> to <u>11-26-19-83</u> , that (I) (we) last saw the deceased alive on <u>11-26-19-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Robert Stoltz</i>   |  |   |  | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |   |  | 22c. DATE SIGNED<br>11-26-83   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT STOLTZ, MD   |  |   |  | 22e. ADDRESS<br>6701 NORTH CHARLES STREET (GBMC)   |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>11/30/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Olivet Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Md.                                  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Eline Funeral Home   |  |   |  | ADDRESS<br>Reisterstown, Md.   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conish</i> |  |

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

TO: SAC, NEW YORK (100-157111) FROM: SAC, NEW YORK (100-157111)

SUBJECT: JAMES EARL RAY; AKA; FUGITIVE; RE: MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, APRIL 11, 1968, AND BUREAU TELETYPE TO NEW YORK, APRIL 11, 1968.

RE: NEW YORK TELETYPE TO BUREAU, APRIL 11, 1968, AND BUREAU TELETYPE TO NEW YORK, APRIL 11, 1968.

RE: NEW YORK TELETYPE TO BUREAU, APRIL 11, 1968, AND BUREAU TELETYPE TO NEW YORK, APRIL 11, 1968.

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RE: NEW YORK TELETYPE TO BUREAU, APRIL 11, 1968, AND BUREAU TELETYPE TO NEW YORK, APRIL 11, 1968.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Sarah RUTH Freedman</i>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>Nov. 7, 1983</i>   |  | 2b. HOUR<br><i>0720 A</i>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br><i>DEC. 7, 1906</i>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>                                  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   | 13e. STREET ADDRESS<br><b>3203 GREENMEAD RD. #21207</b>   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY ROTHMAN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>DOA UNKNOWN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>219-58-6474</b>   | 17. INFORMANT<br><b>MRS. IRMA SCHINDLER</b><br><b>3806 KILBURN RD. RANDALLSTOWN, MD 21133</b>   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b><br><b>0389</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>SEPTICEMIA - SOURCE?</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Alan Rosenbloom MD</i>   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><i>11/7/83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ALAN ROSENBLUM MD</b>   |   | 22e. ADDRESS<br><b>436 RANDOM RD BALTO MD 21229</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   | 23b. DATE<br><b>NOV. 8, 1983</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MIKRO KODESH=BETH ISRAEL</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>              |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1983</b>   |  |  |
|   |   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connelley</i>  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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• *Journal of the American Academy of Child and Adolescent Psychiatry*, 1999, 38(12):1369-1375

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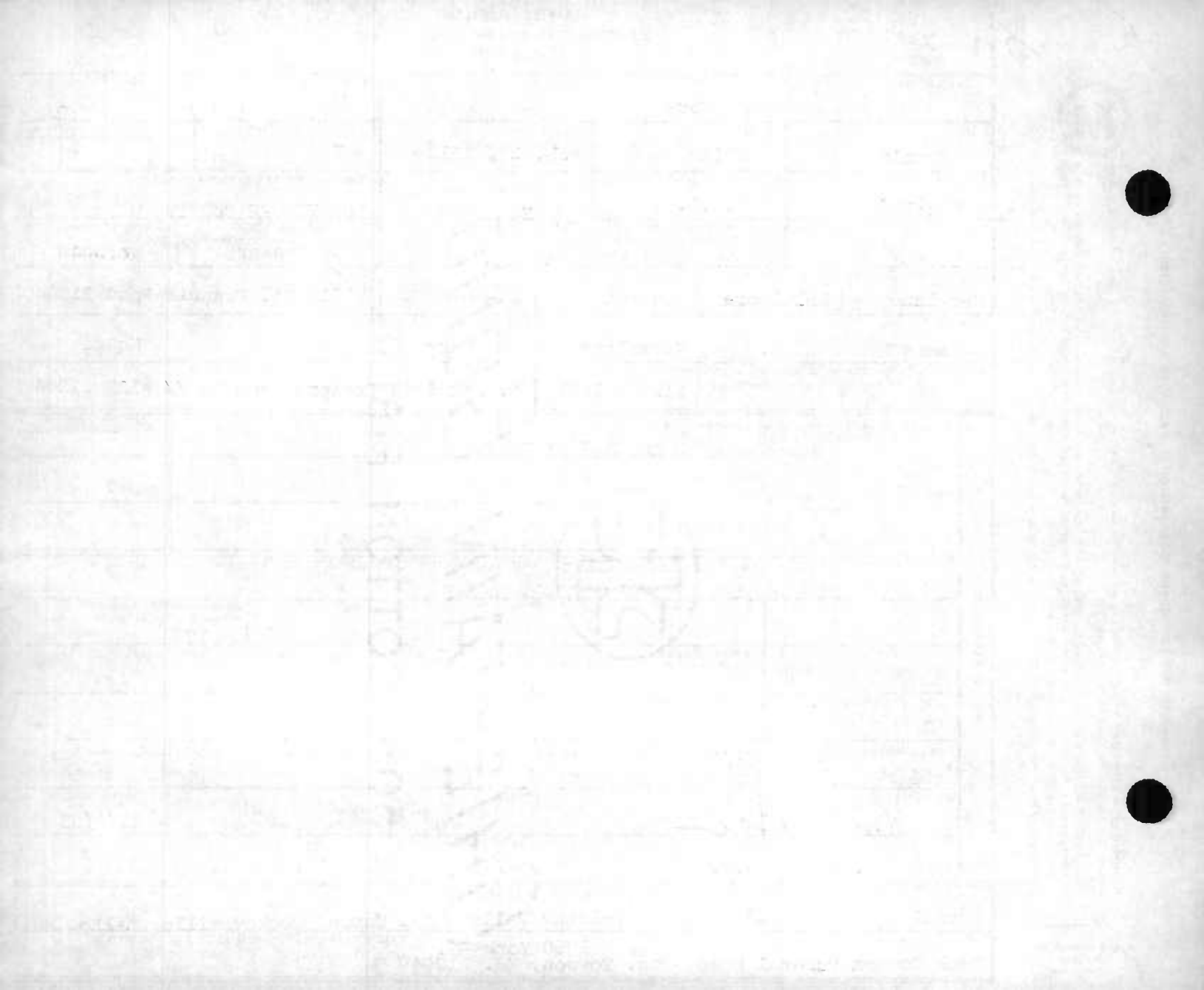


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |   |  |  |                                   |  |
|--|--|---|--|---|---|--|--|-----------------------------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |   |  |   | REG. NO.  |  |  |                                   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   |  |   | 2a. DATE OF DEATH   |  |  |                                   |  |
| FIRST MIDDLE LAST<br>ROSE Mary FREIERT   |  |   |  |   | MONTH DAY YEAR HOUR<br>11/4/83 8:28a M                              |  |  |                                   |  |
| 3. SEX   |  | 4. RACE   |  | 5. DATE OF BIRTH  |   | 6. AGE (IN YEARS LAST BIRTHDAY)                                  |  | 7. IF UNDER 1 YEAR                |  |
| Female   |  | White   |  | MONTH DAY YEAR<br>Feb. 29, 1912   |   | 71   |  | MONTHS DAYS HOURS MIN.            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                                   |  |
| Maryland   |  | U.S.A.  |  |   |   | BALTIMORE COUNTY MD.   |  |                                   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| TOWSON   |  | GREATER BALTIMORE MEDICAL CENTER  |  |   |   | Homemaker  |  | Own Home                          |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   | 13d. INSIDE CITY LIMITS?  |  |  |                                   |  |
| 13a. STATE<br>Maryland   |  |   |  |   | 13b. CITY OR TOWN<br>Towson   |  |  |                                   |  |
| 13c. CITY OR TOWN  |  |   |  |   | 13e. STREET ADDRESS   |  |  |                                   |  |
| Baltimore  |  |   |  |   | 515 St. Francis Road 21204  |  |  |                                   |  |
| 14. FATHER'S NAME  |  |   |  |   | 15. MOTHER'S MAIDEN NAME  |  |  |                                   |  |
| FIRST MIDDLE LAST<br>James M. McFarland  |  |   |  |   | FIRST MIDDLE LAST<br>Mary C. McGee                                  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)             |  | 17. INFORMANT ADDRESS  |                                   |  |
| NO   |  |   |  |   | 216-09-1911   |  | R. Patricia Freiert Same As #7 #13E 21204                      |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY FIBROSIS</u><br>5150<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |   |  |  |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |  |  |                                   |  |
| GI BLEEDING DUE TO GASTRIC ULCERS  |  |   |  |   |   |  |  |                                   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                                   |  |
|  |  |   |  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                                   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |                                   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |                                   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>83</u> , to <u>11/4</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>11/4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE<br><u>John E. Adams</u><br>DEGREE  |  |   | 22c. DATE SIGNED<br>11/4/83   |  |  |                                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |   |   |  |  |                                   |  |
| JOHN E. ADAMS, M.D.  |  | 6701 N. CHARLES ST. BALTO., MD 21204  |  |   |   |  |  |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                       |  |                                   |  |
| Burial   |  | 11-7-83   |  | Dulaney Valley Mem. Gards   |   | Cockeysville, Balto. Md.   |  |                                   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE                                       |  |                                   |  |
| Ruck Towson Funeral Home, Inc.   |  | 1050 York Rd. Towson, Md. 21204   |  | 10/17/83  |   | <u>John J. Conner</u>  |  |                                   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |   |   |  |  |
|--|--|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Walter Saulsbury Frizzell Sr.</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 12 1983</b>                        |   |   | 2b. HOUR<br><b>12:05A</b>  |   |   |  |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>Caucasion</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>March 20 1919</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>IF UNDER 24 HRS. |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                      |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore Co.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Music Teacher</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dulaney Studio</b>    |  |  |
| 13a. STATE<br><b>Maryland</b>  |  |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Parkville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS / ZIP CODE<br><b>3052 Arizona Avenue 21234</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John C. Frizzell</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Margaret Geese Frizzell</b>   |   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WW 2 214-18-2119</b> |   | 17. INFORMANT<br>NAME ADDRESS<br><b>Mrs. Ruth Frizzell 21234</b><br><b>3052 Arizona Avenue Parkville Maryland</b> |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>AS CVD - acute MI.</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |  |  |   |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |   |  |   |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERNIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                                     |  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)              |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/12/83</b> to <b>11/14/83</b> , that (I) (we) last saw the deceased alive on <b>11/13/83</b> , and that (I) (we) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                                      |  |  |  |   |   |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Donald W. Mintzer MD</b>  |  |  |  |   | DEGREE<br><b>MD</b>   |  | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/14/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Donald W. Mintzer MD</b>   |  |  |  |   | 22e. ADDRESS<br><b>3009 Evergreen Avenue 21214</b>  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>11-15-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Memorial Park</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Sykesville Carroll Maryland</b>  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Loring Byers Funeral Directors, Inc.</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>  |   |  |  |
| 8728 Liberty Road Randallstown, Maryland 21133   |  |  |  |   |   |  |   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, mostly illegible text and markings across the page, possibly bleed-through from the reverse side.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>VIRGINIA</b>   |  | FIRST <b>Virginia</b> MIDDLE <b>Ann</b> LAST <b>Gabriszeski</b>  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>26</b> YEAR <b>83</b>   |  | 2b. HOUR <b>5:50 AM</b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH <b>July</b> DAY <b>20</b> YEAR <b>1932</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>51</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                                    |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>STELLA MARIS HOSPICE</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Order Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Food Broker</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> |  | 13b. COUNTY <b>Baltimore</b>   |  | 13c. CITY OR TOWN <b>Middle River</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |  |
| 13e. STREET ADDRESS<br><b>1306 Fuselage Ave. 21220</b>   |  | 14. FATHER'S NAME FIRST <b>Harry C.</b> MIDDLE <b>Hershey</b> LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Mary Louise</b> MIDDLE <b>Gardner</b> LAST   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>216 28 2412</b>   |  | 17. INFORMANT ADDRESS<br><b>Mary L. Hershey Same</b>   |  |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **HEART FAILURE**

1629  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **LUNG CARCINOMA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**BRAIN Metastasis**

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR <b>A.M.</b> MONTH <b>11</b> DAY <b>26</b> YEAR <b>1983</b> |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)    |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                 |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-24</b> , 19 <b>83</b> , to <b>11-26</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>11-26</b> , 19 <b>83</b> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>K. Faulkner MD</b>   |  |   |  | DEGREE  |  | 22c. DATE SIGNED <b>11-26-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FAULKNER</b>  |  |   |  | 22e. ADDRESS <b>2300 Dulaney Valley Rd.</b>                                       |  |   |  |

|  |  |                                |  |   |  |  |  |
|--|--|--------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b> |  | 23b. DATE <b>Nov. 28, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crematory</b> |  | 23d. LOCATION CITY OR TOWN <b>Baltimore</b> COUNTY <b>Maryland</b> STATE |  |
| 24. FUNERAL DIRECTOR <b>Brazdzinski Funeral Home</b>       |  |                                |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>                |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

WATER-PROOFING

WATER-PROOFING

WATER-PROOFING

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WATER-PROOFING

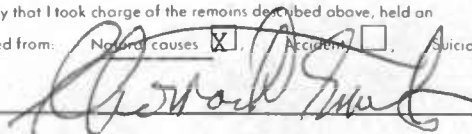
WATER-PROOFING

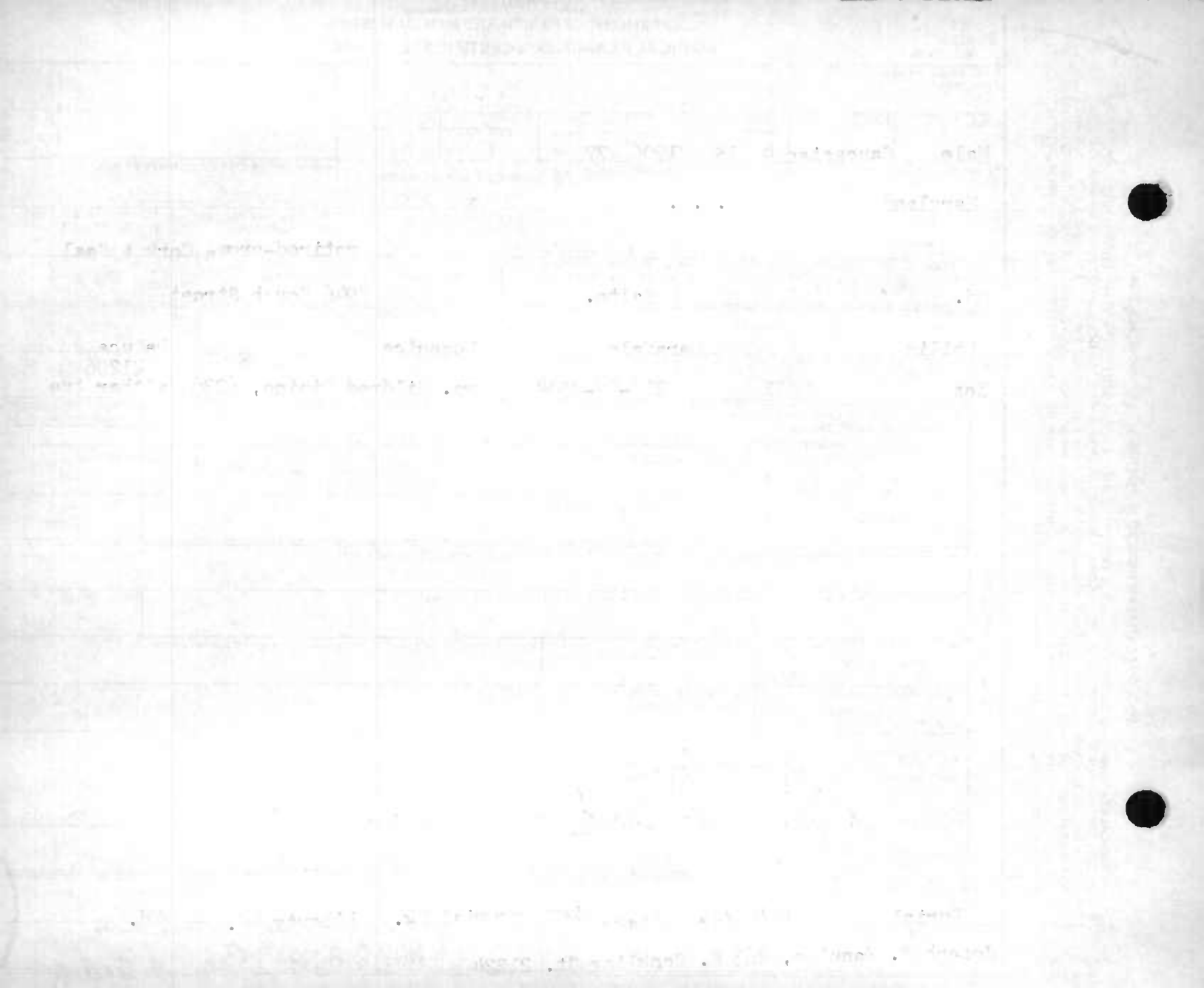
WATER-PROOFING

100% COTTON

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |  |  |   |  |  |  | REG. NO. 2 8 8 2 5   |  |
|---|--|----------------------|--|--|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR  |  |                      |  |  |  |   |  |  |  | 7a. DATE KNOWN OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Joseph Garafalo   |  |                      |  |  |  |   |  |  |  | 2. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 11 21 19 83 |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Caucasian |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>4 15 1906   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>77                                    |  | 7. IF UNDER 1 YR. MONTHS DAYS  |  | 7b. HOUR<br>9:45 PM  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                    |  |
| 10. CITY OR TOWN OF DEATH<br>Essex  |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>7946 Gough Street |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>retired-cronk Cork & Seal   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br>Md.   |  |                      |  | 13b. COUNTY<br>Balt.   |  | 13c. CITY OR TOWN<br>Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>7946 Gough Street 21224                                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Philip Garafalo  |  |                      |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Domenica DeLuca                 |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)<br>Yes   |  |                      |  | 16b. SOCIAL SECURITY NO.<br>218-09-0544  |  | 17. INFORMANT ADDRESS<br>Mrs. Mildred Cimino, 6236 Walther Ave 21206          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u><br>4292<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ |  |                      |  |  |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 19a. DATE OF OPERATION  |  |                      |  |  |  |   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                |  |
| 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                      |  |  |  |   |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |  |                      |  |  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br>   |  |                      |  | TITLE (SPECIFY)<br>M.D. Deputy Chief   |  |   |  | DATE SIGNED<br>11/24/83  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br>Thomas D. Smith, M.D.  |  |                      |  | ADDRESS<br>111 Penn St.  |  |   |  | BALTO., MD.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  |                      |  | 23b. DATE<br>11/26/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lake View Memorial Pk.                  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Liberty Rd Md.  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Joseph N. Zannino, 263 S. Conkling St. 21224   |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 28 1983                                  |  | 25b. REGISTRAR'S SIGNATURE<br>                                      |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |   |  |  |
|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hiatt Hiatt G. Gaston  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 28 83 |   |   | 2b. HOUR<br>10 <sup>00</sup> AM  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov 3 1892  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>91 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>York, Pa   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Manor Care Towson Nursing Home |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Treasurer- Alexander & Alexander |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |   |   |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Maryland  |  |   |   |   |   |  |  |
| 13c. COUNTY<br>Baltimore  |  | 13d. CITY OR TOWN<br>Randallstown   |   | 13e. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13f. STREET ADDRESS<br>3707 Lanamer Road, 21133  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>215-03-1947  |   | 17. INFORMANT<br>ADDRESS<br>Germaine M. Judd, 904 Fairmount Ave. 21204  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i><br>4292<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>arteriosclerotic Cardiovascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>only 34 HS   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) <del>this hospital</del> attended the deceased from <i>24 February 82</i> to <i>11-28</i> 19 <i>83</i> , that (I) <del>lost</del> saw the deceased alive on <i>19</i> , and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>met</del> (did) (did not) view the body after death.                      |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><i>Walter T. Kees</i> MD  |  |   |   | 22c. DATE SIGNED<br>11/28/83  |   | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>WALTER T. KEES  |  |
| 22e. ADDRESS<br><i>Monkton, Md 21111</i>  |  |   |   | 22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>             |   | 22g. DATE RECD BY REGISTRAR  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>11-30-83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Druid Ridge Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pikesville, Balto, Maryland                            |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204  |  |   |   | 25a. DATE RECD BY REGISTRAR<br>DEC 1 1983   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





NOTICE

DEC 1 1961

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |   |   |   |  |   |  |  |
|---|--|---|---|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SAMUEL GAMERMAN</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 6 83</b>                                   |   |   | 2b. HOUR<br><b>2:50AM</b>  |   |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 13, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN<br><b>0 0 0 0</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GENERAL HOSPITAL</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>RETAIL</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>6938 BROOKMILL RD. APT. 2C (21215)</b>   |  |   | 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ABRAHAM GAMERMAN</b>                       |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ROSE UNKNOWN</b>   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>WWII-ARMY 212-07-5760</b> |   | 17. INFORMANT<br>ADDRESS (21215)<br><b>MRS. HINDY GAMERMAN 6938 BROOKMILL RD. APT. 2C</b> |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>5693 RECURRENT VENTRICULAR TACHYCARDIA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>HYPOTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>POSSIBLE GRAM NEGATIVE SEPSIS</b>           |  |   |   |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>LEFT HEMIPLEGIA AND APHASIA SECONDARY TO C.V.A.</b>  |  |   |   |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br><b>10/30/83</b>   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>RECTAL BLEEDING</b>              |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |   |   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Haifeez A Syed M.D.</b>  |  |   |   |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/6/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HAIFEEZ A SYED M.D.</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>BALTIMORE COUNTY GEN. HOSP.</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>11/7/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BEHRENS ISRAEL CEM</b>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MARYLAND</b>                         |  |  |
| 24. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., INC.</b>   |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |  |
| 6010 REISTERSTOWN RD. BALTIMORE, MARYLAND 21215   |  |   |   |   |   |  |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF LAND MANAGEMENT

WATER RIGHTS

STATE OF CALIFORNIA

WATER RIGHTS

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Hilda German   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-13-38                   |  | 2b. HOUR<br>5:50 PM   |  |
| 3. SEX<br>F   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Dec. 6, 1915  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS                                 |  | 7. IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland                                       |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA                               |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY Baltimore county MD                          |  | 10. CITY OR TOWN OF DEATH<br>BALTA Towson                         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. St Joseph Hospital                         |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Supervisor Credit Union |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Clothing                     |  | 13a. STREET ADDRESS<br>3024 Oak Forest Rd, 21234  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Baltimore  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John W. Frederick                                 |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Pearl E. Roberts |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |
| 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-05-1620                      |  | 17. INFORMANT<br>Fred S. German                                   |  | ADDRESS<br>Same   |  |

|  |  |   |
|--|--|---|
| <b>18 CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br><b>PART I. DEATH WAS CAUSED BY:</b> |  | <b>APPROXIMATE INTERVAL<br/>BETWEEN ONSET AND DEATH</b> |
| <b>IMMEDIATE CAUSE (a)</b> <u>Gram Neg Sepsis</u>  | <b>Gram negative sepsis</b>  | <u>2 days</u>   |
| <b>1830</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.          | DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma of the ovary with peritoneal implants</u><br>(b) <u>Carcinoma of the ovary with peritoneal implants</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Malignant pleural effusion</u><br>(c) <u>Malignant pleural effusion</u> | <u>1 1/2 mo</u>   |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

|                        |  |  |  |
|------------------------|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|------------------------|--|--|--|

|                     |  |  |  |              |        |       |
|---------------------|--|--|--|--------------|--------|-------|
| MEDICAL CERTIFICATE | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2) |              |        |       |
|                     | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET  | CITY OR TOWN | COUNTY | STATE |

22a. I certify that (I) (this hospital) attended the deceased from Sept, 1982, to Nov, 1982, that (I) (we) lost saw the deceased alive on 11/13, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.

|  |  |  |                                     |
|--|--|--|-------------------------------------|
| 22b. SIGNATURE<br><i>Art Serpick</i>   | DEGREE<br><i>MD</i>  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><i>11/13/85</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Arthur Serpick, M.D.</b><br><i>A Serpick</i> | 22e. ADDRESS<br><i>St</i> <b>7620 York Road Towson Md 21204</b><br><i>Harold Harpold</i> |  |                                     |

|  |                                   |  |   |
|--|-----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                    | 23b. DATE<br><b>Nov. 17, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Pk.</b> | 23d. LOCATION<br>CITY OR TOWN<br><b>Parkville, Balto. Co., Md.</b><br>COUNTY<br>STATE                   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Mitchell-Wiedefeld Home, Inc. Balto., Md.</b> |                                   | ADDRESS<br><b>6500 York Rd.</b>                                | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1983</b><br>25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |

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WILLIAM W. WILSON, JR., Inc., 1000 15th St. N.W., Washington, D.C. 20004

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

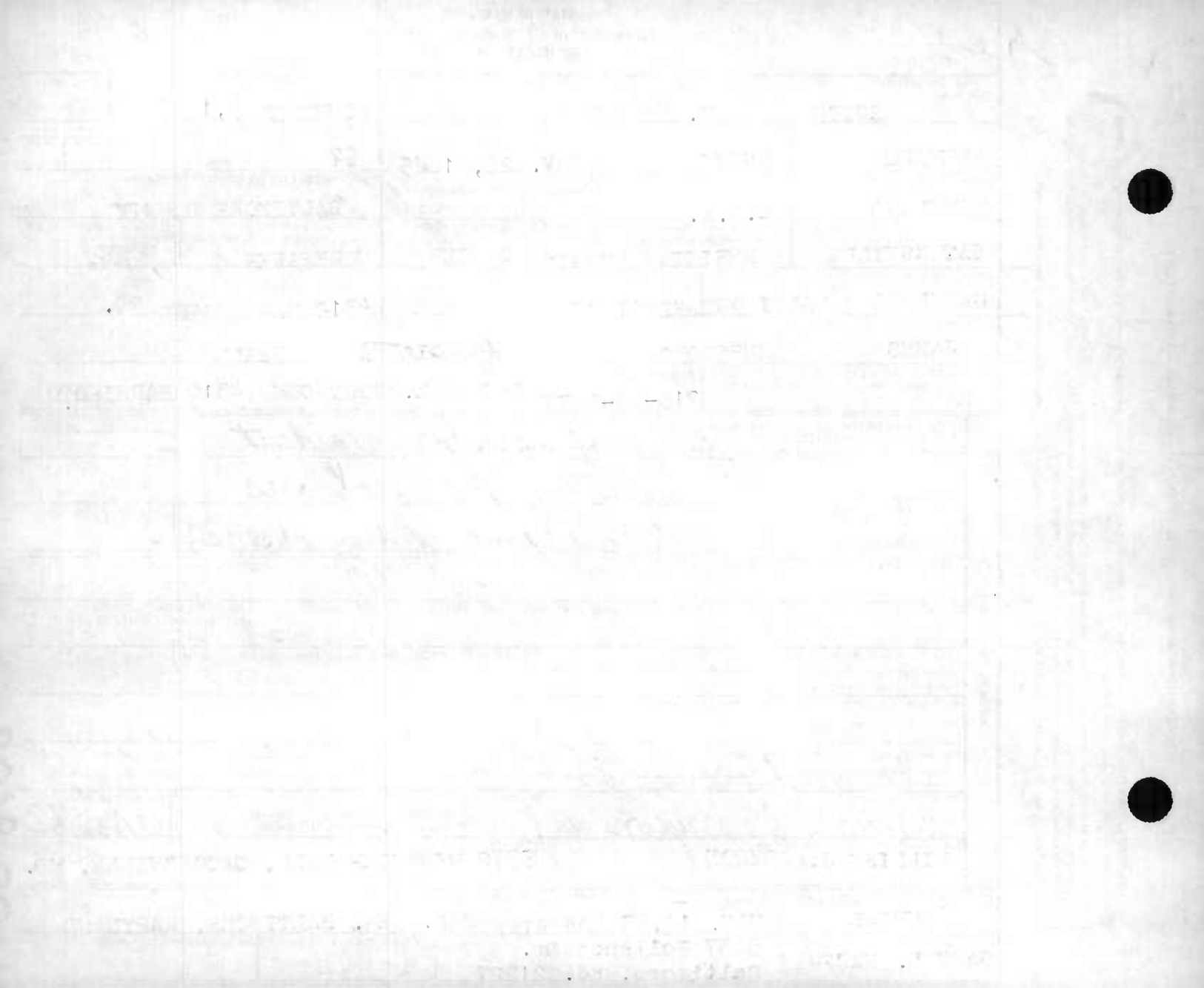
|  |  |   |   |   |                   |  |   |  |                           |   |  |
|--|--|---|---|---|-------------------|--|---|--|---------------------------|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |   | FIRST MIDDLE LAST                             |   |                   | 2a. DATE OF DEATH MONTH DAY YEAR   |   |  |                           | 2b. HOUR  |  |
| EDITH  |  |   | G. GEYER                                      |   |                   | NOVEMBER 9, 1983   |   |  |                           | M   |  |
| 3. SEX   |  | 4. RACE   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR  |                   | 6. AGE (IN YEARS LAST BIRTHDAY)  |   | IF UNDER 1 YEAR<br>MONTHS DAYS   |                           | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| FEMALE   |  | WHITE   |   | NOV. 20, 1885   |                   | 97 YRS.  |   |  |                           |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                   | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                           |   |  |
| MARYLAND   |  | U.S.A.  |   |   |                   | BALTIMORE COUNTY MD.   |   |  |                           |   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |                   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |   | 12b. KIND OF BUSINESS OR INDUSTRY  |                           |   |  |
| CATONSVILLE  |  | MERIDIAN NURSING CENTER   |   |   |                   | HOMEMAKER  |   | HOME   |                           |   |  |
| 13a. STATE   |  |   | 13b. COUNTY                                   |   | 13c. CITY OR TOWN |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS       |   |  |
| MARYLAND   |  |   | BALTIMORE                                     |   | KENSINGTON        |  |   |  | 4310 BARRINGTON RD. 20895 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST |   |                   | 16. SOCIAL SECURITY NO.  |   |  |                           |   |  |
| JAMES ARMSTRONG  |  |   | GEORGIANNA BEALL                              |   |                   | 215-76-2877  |   |  |                           |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |   | 16b. SOCIAL SECURITY NO.                      |   |                   | 17. INFORMANT ADDRESS  |   |  |                           |   |  |
| NO   |  |   | 215-76-2877                                   |   |                   | THELMA E. SOUTHCOMB 4310 BARRINGTON RD.  |   |  |                           |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>4039 IMMEDIATE CAUSE (a) Cerebral vascular accident<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Generalized arteriosclerosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Arteriosclerotic kidney disease |  |   |   |   |                   |  |   |  |                           | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |   |   |                   |  |   |  |                           |   |  |
| 19a. DATE OF OPERATION   |  |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                           | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |  |                           |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |                   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                           |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9 Nov 83 to 9 Nov 83 that (I) (we) lost<br>saw the deceased alive on 9 Nov 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |   | 22b. SIGNATURE<br>William J. Bryson M.D.  |                   | 22c. DATE SIGNED<br>15 Nov 83  |   |  |                           |   |  |
| 22b. SIGNATURE<br>WILLIAM J. BRYSON  |  |   |   | 22c. DATE SIGNED<br>15 Nov 83   |                   | 22d. ADDRESS<br>5772 WESTVIEW MALL, CATONSVILLE, MD.                           |   |  |                           |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |   |   | 23b. DATE   |                   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |                           |   |  |
| BURIAL   |  |   |   | NOV. 12, 83   |                   | LORRAINE PRK. CEM.   |   | BALTIMORE, MARYLAND  |                           |   |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  |   |   | 24b. ADDRESS  |                   | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE   |                           |   |  |
| GARY L. KAUFMAN  |  |   |   | 5837 Bellanca Dr.<br>Baltimore, Md. 21227   |                   | NOV 14 1983  |   | [Signature]  |                           |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



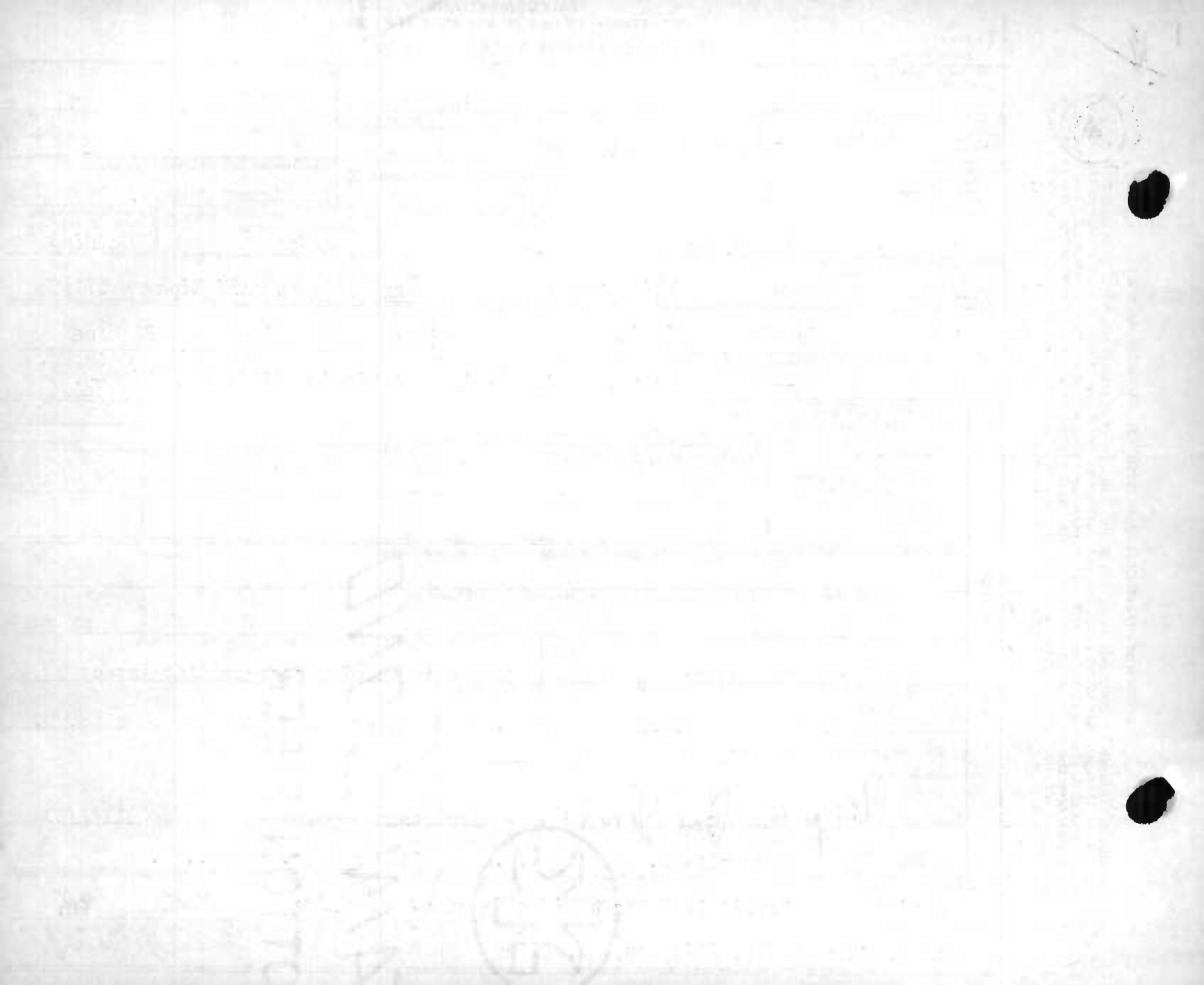


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 28830  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Ronnie Lynn Gilliam</b>  |  |  |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>8</b> YEAR <b>1983</b> |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b>   |  | 5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>3</b> YEAR <b>1957</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>26</b> YRS.   |  | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>            |  | 2c. DATE PRONOUNCED DEAD <b>11 8 1983</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD</b>   |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>White Marsh</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 40 at Jones Rd.</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Welder</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Welding</b>                                 |  |   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Balto</b>   |  | 13c. CITY OR TOWN <b>White Marsh</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  | 13e. STREET ADDRESS <b>11038 Pulaski Highway 21162</b>                           |  |   |  |
| 14. FATHER'S NAME FIRST <b>Lee</b> MIDDLE <b>Roy</b> LAST <b>Gilliam</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Shirley</b> MIDDLE <b>Ann</b> LAST <b>Bledsoe</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>   |  |  |  | 16b. SOCIAL SECURITY NO. <b>212-70-8927</b>  |  | 17. INFORMANT ADDRESS <b>Shirley A. Gilliam, 11038 Pulaski Hwy. 21162</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cranio cerebral trauma</b><br><b>8120</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>(c) <b></b>  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>2:26 PM 11 8 1983</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>driver in auto/tractor-trailer impact</b> |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>  |  | 21f. LOCATION STREET <b>Rt. 40 at Jones Rd.</b> CITY OR TOWN <b>White Marsh</b> COUNTY <b>Balto</b> STATE <b>Md.</b>       |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Margarita A. Korell</b>  |  |  |  | TITLE (SPECIFY) <b>M.D. Assistant</b>  |  |  |  | DATE SIGNED <b>11/8/83</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>   |  |  |  | ADDRESS <b>111 Penn St. Balto., MD.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>Nov. 10, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN <b>Delta</b> COUNTY <b>York</b> STATE <b>Pa.</b>  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Howard K. McComas III</b> ADDRESS <b>Abingdon, Md. 21009</b>  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>                                 |  |   |  |



BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28831

REG. NO.

|   |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
|---|--|--|--|---|--|-----------------------------------|--|---------------------|--|---------------------|--|--------------------------------------|--|-----------|--|
| 1. FOR STATE REGISTRAR  |  | 2. DATE KNOWN OF DEATH                                   |  |   |  |                                   |  |                     |  |                     |  | 2b. HOUR                             |  |           |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST                              |  | MONTH               |  | DAY                 |  | YEAR                                 |  | 2b. HOUR  |  |
| HENRY JOHN GNAU Sr.   |  |  |  |   |  |                                   |  | 11                  |  | 13                  |  | 1983                                 |  | 3:40 P.M. |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS)                 |  | IF UNDER 1 YR.      |  | IF UNDER 24 HRS.    |  | 7c. DATE PRONOUNCED DEAD             |  | 2d. HOUR  |  |
| Male  |  | White  |  | Nov. 30 1925  |  | 57 YRS.                           |  | MONTHS              |  | DAYS                |  | HOURS                                |  | MIN.      |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?                             |  | 8. MARRIED  |  | NEVER MARRIED                     |  | WIDOWED             |  | DIVORCED            |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  | MD.       |  |
| Maryland  |  | U.S.A.   |  | YES   |  | NO                                |  | YES                 |  | NO                  |  | Baltimore County                     |  |           |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |                     |  |                     |  |                                      |  |           |  |
| Woodlawn  |  | 170 at Woodlawn  |  | Supervisor  |  | Grocery                           |  |                     |  |                     |  |                                      |  |           |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY   |  | 13d. INSIDE CITY LIMITS?          |  | 13e. STREET ADDRESS |  |                     |  |                                      |  |           |  |
| Maryland  |  | Harford  |  | Joppa   |  | YES                               |  | 211 Chell Rd.       |  |                     |  |                                      |  |           |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME                                 |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?                  |  | 16b. SOCIAL SECURITY NO.          |  | 17. INFORMANT       |  |                     |  |                                      |  |           |  |
| Reuben  |  | Beatrice K. Treackle                                     |  | YES   |  | 212-20-5300                       |  | Elizabeth A. Gnau   |  |                     |  |                                      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| PART I DEATH WAS CAUSED BY:   |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| IMMEDIATE CAUSE (a)   |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| 4100 acute Myocardial Infarction  |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.                                       |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| (b)   |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| (c)   |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?        |  | 20. AUTOPSY?  |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
|   |  |  |  | YES   |  | NO                                |  |                     |  |                     |  |                                      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH   |  | 21b. TIME OF INJURY                                      |  | 21c. HOW INJURY OCCURRED                                      |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
|   |  | HOUR A.M. MONTH DAY YEAR                                 |  | ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2            |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
|   |  | P.M. 19  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK  |  | 21e. PLACE OF INJURY                                     |  | 21f. LOCATION   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
|   |  | AT HOME STREET, FACTORY, FARM, ETC.)                     |  | STREET CITY OR TOWN COUNTY STATE                              |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held on   |  | Autopsy  |  | Inspection  |  | Inquiry                           |  | and in my opinion   |  |                     |  |                                      |  |           |  |
| death resulted from:  |  | Natural causes   |  | Accident  |  | Suicide                           |  | Homicide            |  | Undetermined manner |  |                                      |  |           |  |
| ACTUAL SIGNATURE  |  | TITLE (SPECIFY)  |  | M.D.  |  | MEDICAL EXAMINER                  |  | DATE SIGNED         |  |                     |  |                                      |  |           |  |
| Stanley Z. Feigenberg   |  |  |  |   |  |                                   |  | 11/13/83            |  |                     |  |                                      |  |           |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |  | ADDRESS  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| Stanley Z. Feigenberg M.D.  |  | 7131 Liberty Rd  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                            |  | 23d. LOCATION                     |  |                     |  |                     |  |                                      |  |           |  |
| BURIAL  |  | Nov. 16, 1983  |  | Cedar Hill Cemetery   |  | Brooklyn Pk                       |  |                     |  |                     |  |                                      |  |           |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D BY REGISTRAR                             |  | 25b. REGISTRAR'S SIGNATURE                                    |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| Howard K. McComas III   |  | NOV 16 1983  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| ADDRESS   |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |
| Abingdon, Maryland  |  |  |  |   |  |                                   |  |                     |  |                     |  |                                      |  |           |  |

Anne Arundel County, MD.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

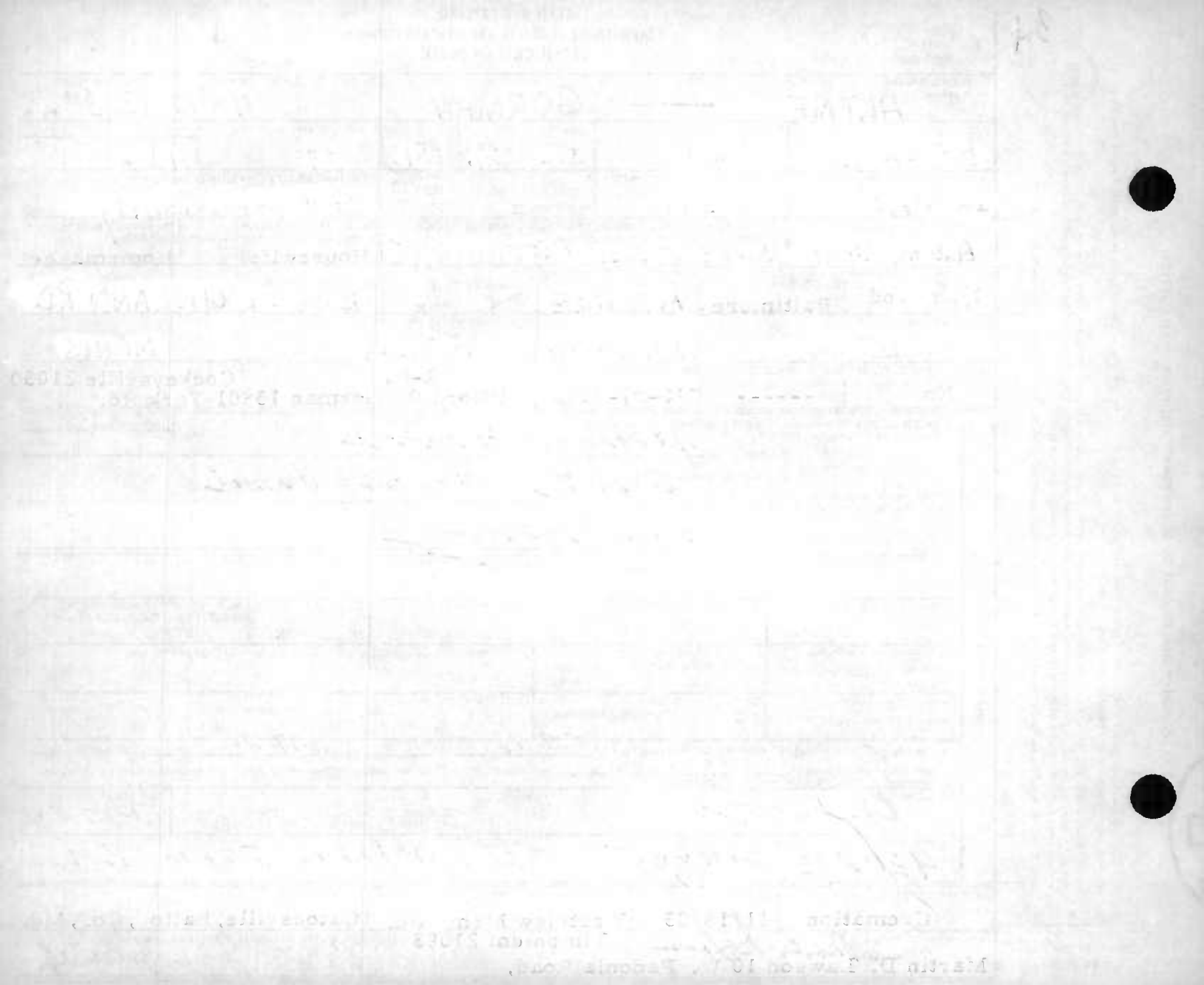
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 28832   |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |   |  |
| ALINE GORMAN  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 11 17 83  |  |   |  |
| 3. SEX Female   |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR June 11, 1884  |  | 2b. HOUR 3:10 A.M.  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.   |  | 7b. CITIZEN OF WHAT COUNTRY? USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY GIVE STREET ADDRESS) Meridian Nursing Home |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY Homemaker   |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Baltimore   |  | 13c. CITY OR TOWN Catonsville  |  | 13d. STREET ADDRESS 16 Fusting Avenue #21228.   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST William VanNostrand   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Monks   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No   |  |   |  |
| 16a. SOCIAL SECURITY NO. 216-07-8560  |  | 17. INFORMANT R-6   |  | ADDRESS Cockeysville 21030 Clifford R. Gorman 13801 York Rd.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |   |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) 4292 - Chronic renal   |  |   |  |  |  |   |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) 4292 - Chronic renal   |  |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-9-76, 19, to 11-17-83, 19, that (I) (we) lost saw the deceased alive on 11-15-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE [Signature]  |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED 11-17-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE ANGUS  |  | 22e. ADDRESS 3250 Wilkins Drive Balto   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE 11/18/83  |  | 23c. NAME OF CEMETERY OR CREMATORY Westview Mem. Pk.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., Co., Md.   |  |
| 24. FUNERAL DIRECTOR NAME Martin D. Lawson  |  | ADDRESS Timonium 21098  |  | DATE REC'D. BY REGISTRAR NOV 21 1983   |  | 25. REGISTRAR'S SIGNATURE [Signature]   |  |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28833

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 2. DATE OF DEATH   |  | MONTH DAY YEAR  |  | 7. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2. DATE OF DEATH  |  | 7. HOUR   |  |
| MARY GORNIK-GORNIK  |  |  |  | NOV. 5 1983   |  | 11:50 PM  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| FEMALE  |  | White  |  | MONTH DAY YEAR<br>2 14 06   |  | 77 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Ohio  |  | U. S. A.   |  |   |  | BALTIMORE COUNTY MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| OWSON, MD.  |  | GBMC-6701 N. CHARLES ST.   |  | Housewife   |  |   |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| Md.   |  | Balto.   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS / ZIP CODE  |  | 13f. CITY OR TOWN   |  |
| FIRST MIDDLE LAST<br>John Pryjtel   |  | FIRST MIDDLE LAST<br>Jennie Boldan   |  | 3905 East Joppa Rd. Balto., Md. #21236  |  | Apt. A  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT   |  | ADDRESS   |  |
|   |  | 292-12-9147  |  | Raymond F. Cornik   |  | #21204  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>TERMINAL METASTATIC CARCINOMA OF THE COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1983, to 11/05, 1983, that (I) (we) last saw the deceased alive on 11/05, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
| EDWARD P. GRACE, M.D.   |  |  |  | 11/6/83   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  | 22f. REGISTRAR'S SIGNATURE  |  |   |  |
| EDWARD P. GRACE, M.D.   |  | GBMC-6701 N. CHARLES ST. 21204   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial  |  | 11-10-83   |  | Calvary Cemetery  |  | Cleveland Ohio  |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| G. Truman Schwab  |  | NOV 14 1983  |  | John J. Connel  |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For the purpose of this law, the death certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages of this certificate should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|---|--|
| FOR<br>1- STATE REGISTRAR   |  |   |  |   | REG. NO.   |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Benny Paul GRADO   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>Nov. 15, 1983   |  |  | 2b. HOUR<br>8:00A <sub>M</sub>   |   |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Sept 19, 1940   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>43 YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.                        |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Fullerton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>4801 Hilltop Court 21236 |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Repairman        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Watches   |   |  |
| 13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>Fullerton                                   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul C. Grado   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Helen Lubek   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>220-36-3765 |   | 17. INFORMANT<br>ADDRESS: Baltimore, Md.<br>Mary T. Grado 4801 Hilltop Ct. 21236   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4241 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive Heart Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aortic Valve Disease</u>                                |  |   |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>30 minutes<br>5 years<br>40 years               |  |
| PART 2. OTHER SIGNIFICANT CAUSES CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |   |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost<br>saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br>Jeffrey Cole, M.D.  |  |   |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br>11/16/83   |   |  |
| 22d. PHYSICIAN (TYPE OR PRINT)<br>Jeffrey Cole, M.D.  |  |   |  |   | 22e. ADDRESS<br>St. Aganes Hopstrial Balto., Md.   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |   | 23b. DATE<br>Nov 18, 83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md. |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Dana Funeral Homes, Inc.  |  |   |  |   | ADDRESS<br>7110 Belair Road<br>Baltimore, Md.  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 16 1983                     |  |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be returned within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  |   |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8 5 2 8 8 3 5  |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>E dward GORDON GRAU</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>11 25 83</b>  |  |   |  | 2b. HOUR <b>0321A M</b>   |  |  |  |
| 3. SEX <b>MALE</b>  |  | 4. RACE <b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>10 19 1920</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>63</b> YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.                  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>ST JOSEPH HOSPITAL</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PHYSICIAN</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |   |  | 13a. STATE <b>MARYLAND</b>  |  |   |  | 13b. COUNTY <b>BALTO.</b>   |  | 13c. CITY OR TOWN <b>LONG GREEN</b>  |  |
|   |  |   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS <b>LONG GREEN &amp; MANOR RD.</b>                             |  |   |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Otto Grau</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Hoover</b>  |  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>  |  |   |  | 16b. SOCIAL SECURITY NO. <b>213 16 5272</b>   |  | 17. INFORMANT ADDRESS <b>family records</b>                                       |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Heart failure</b><br><b>4110</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery insufficiency</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Arteriosclerotic cardiovascular disease</b>   |  |   |  |   |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.   |  |   |  |   |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)    |  |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from <b>11-25-83</b> , 19 <b>83</b> , to <b>11-25</b> , 19 <b>83</b> , that (we) lost above, the deceased alive on <b>11-25</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |   |  |  |  |
| 22b. SIGNATURE <b>[Signature]</b>   |  |   |  | DEGREE <b>M.D.</b>  |  |   |  | 22c. DATE SIGNED <b>11-25-83</b>  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>REYNALDO ORJUELA-GOMEZ, M.D.</b>   |  |   |  | 22e. ADDRESS <b>St. Joseph's Hospital</b>   |  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>   |  |   |  | 23b. DATE <b>11/28/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Wilson Methodist</b>                        |  | 23d. LOCATION CITY OR TOWN COUNTY <b>Long Green, Balto. County MD.</b>            |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Evans Chapel of Chimes</b>   |  |   |  | ADDRESS <b>2325 York Road</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b>                                   |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - STATE REGISTRAR  |  |         |  | DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |  |  |   |  |                  |  |
|--|--|---------|--|--|--|--|--|--|--|--|--|---|--|------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |         |  | FIRST MIDDLE LAST  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  | 2b. HOUR  |  |                  |  |
| ISABEL GRAVES  |  |         |  |  |  |  |  | 11-21-83   |  |  |  | M   |  |                  |  |
| 3. SEX   |  | 4. RACE |  | 5. DATE OF BIRTH   |  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS. |  |
| F  |  | W       |  | 10-20-1894   |  |  |  | 89 YRS.  |  |  |  | MONTHS DAYS   |  | HOURS MIN.       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |         |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                  |  |
| MARYLAND   |  |         |  | U.S.A.   |  |  |  |  |  |  |  | BALTO. Co MD.   |  |                  |  |
| 10. CITY OR TOWN OF DEATH  |  |         |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                  |  |
| BALTO.   |  |         |  | ARMACOST NURSING HOME  |  |  |  | HOMEMAKER  |  |  |  | HOME  |  |                  |  |
| 13a. STATE   |  |         |  | 13b. COUNTY  |  |  |  | 13c. CITY OR TOWN  |  |  |  | 13d. INSIDE CITY LIMITS?  |  |                  |  |
| MD   |  |         |  |  |  |  |  | BALTO.   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                  |  |
| 14. FATHER'S NAME  |  |         |  | 15. MOTHER'S MAIDEN NAME   |  |  |  | 13e. STREET ADDRESS  |  |  |  | 21206   |  |                  |  |
| FIRST MIDDLE LAST  |  |         |  | FIRST MIDDLE LAST  |  |  |  | 4804 PLEASANT VIEW AVE.  |  |  |  |   |  |                  |  |
| ROBERT EMERSON   |  |         |  | ANNIE BURKHART   |  |  |  |  |  |  |  |   |  |                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |         |  | 16b. SOCIAL SECURITY NO.   |  |  |  | 17. INFORMANT  |  |  |  | ADDRESS   |  |                  |  |
| No   |  |         |  | 217-03-2724D   |  |  |  | Mr. Edward W. Keyser - 1116 Sharon Acres   |  |  |  | 21084   |  |                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |         |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |                  |  |
| PART I. DEATH WAS CAUSED BY:   |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| IMMEDIATE CAUSE (a) 4100   |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) 4100 - old MI - CHF   |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c) Dementia due to multiple infarcts   |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (d) seizure   |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| 19a. DATE OF OPERATION   |  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20a. AUTOPSY?  |  |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                  |  |
|  |  |         |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |   |  |                  |  |
|  |  |         |  | P.M. 19  |  |  |  |  |  |  |  |   |  |                  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  |  | 21f. LOCATION  |  |  |  |   |  |                  |  |
|  |  |         |  |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |                  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 11/21/83 to 11/21/83, that (I) (we) lost   |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| saw the deceased alive on 11/21/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |
| 22b. SIGNATURE   |  |         |  | DEGREE   |  |  |  | 22c. DATE SIGNED   |  |  |  |   |  |                  |  |
| DONALD W. MINDZER  |  |         |  |  |  |  |  | 11/22/83   |  |  |  |   |  |                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |         |  | 22e. ADDRESS   |  |  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  |  |  |   |  |                  |  |
| DONALD W. MINDZER  |  |         |  | 3009 EVERGREEN AVE BALTO   |  |  |  |  |  |  |  |   |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |         |  | 23b. DATE  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |  |  | 23d. LOCATION   |  |                  |  |
| BURIAL   |  |         |  | 11-23-83   |  |  |  | BALTIMORE CEM.   |  |  |  | BALTO. MD.  |  |                  |  |
| 24. FUNERAL DIRECTOR   |  |         |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |   |  |                  |  |
| NAME ADDRESS   |  |         |  | NOV 22 1983  |  |  |  | John J. Connelley  |  |  |  |   |  |                  |  |
| Charles H. De - 7527 Maryland Rd.  |  |         |  |  |  |  |  |  |  |  |  |   |  |                  |  |

BP



| No       | Robert Emerson        | Annie Burkhardt | 217-03-2540 W. Emerson W. Kuyper - 1110 1/2 Street S.W. |
|----------|-----------------------|-----------------|---|
| —        | —                     | —               | —   |
| MD       | BALTO.                | X               | 4804 PLEASANT VIEW AVE                                  |
| BALTO.   | ARMACOST NURSING HOME | HOMEMAKER HOME  |   |
| MARYLAND | U.S.A.                | X               | BALTO. CO.  |
| F        | W                     | 10-20-1894      | 88  |
|          | ISABEL GRAVES         | 11-21-88        |   |

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BALTIMORE (CN)  
JAN 1989

19 Prof. D. 5257. 22/1/25



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |   |
|--|--|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Joseph C. GREELEY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 10, 1983</b>                                 |   | 2b. HOUR<br><b>6:53P<sub>M</sub></b>  |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 12, 1906</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                         |   |
| 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Foreman</b>              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Western Elec.</b>   |
| 13a. STATE<br><b>Md.</b>   | 13b. COUNTY<br><b>-</b>  | 13c. CITY OR TOWN<br><b>Baltimore</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Balto, Md.<br/>7051 Baltimore St, 21224</b>                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joseph Greeley</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Veronica Walsh</b>                          |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-05-5590</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>2701 Reckord Rd.<br/>Carl Greeley, Kingsville, Md. 21087</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4829</b> IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b>   |  |   |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle; margin-left: 10px;">           DUE TO, OR AS A CONSEQUENCE OF<br/>(b) <b>Sepsis</b><br/>           DUE TO, OR AS A CONSEQUENCE OF<br/>(c) <b>Bacterial pneumonia</b> </div>      |  |   |   |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Obtended mental status</b>  |  |   |   |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>November 4, 1983</b> , to <b>November 10, 1983</b> , that (we) last saw the deceased alive on <b>November 10, 1983</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (not) view the body after death. |  |   |   |   |   |
| 22b. SIGNATURE<br><b>Frederick Dressler</b>  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |   | 22c. DATE SIGNED<br><b>11-10-83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRED DRESSLER</b>  |  | 22e. ADDRESS<br><b>9000 FRANKLIN Sq Drive</b>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/14/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garden of Faith</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Md.</b>                         |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Schimunek Funeral Home, 3331 Brehms La,</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 13 5 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |   |

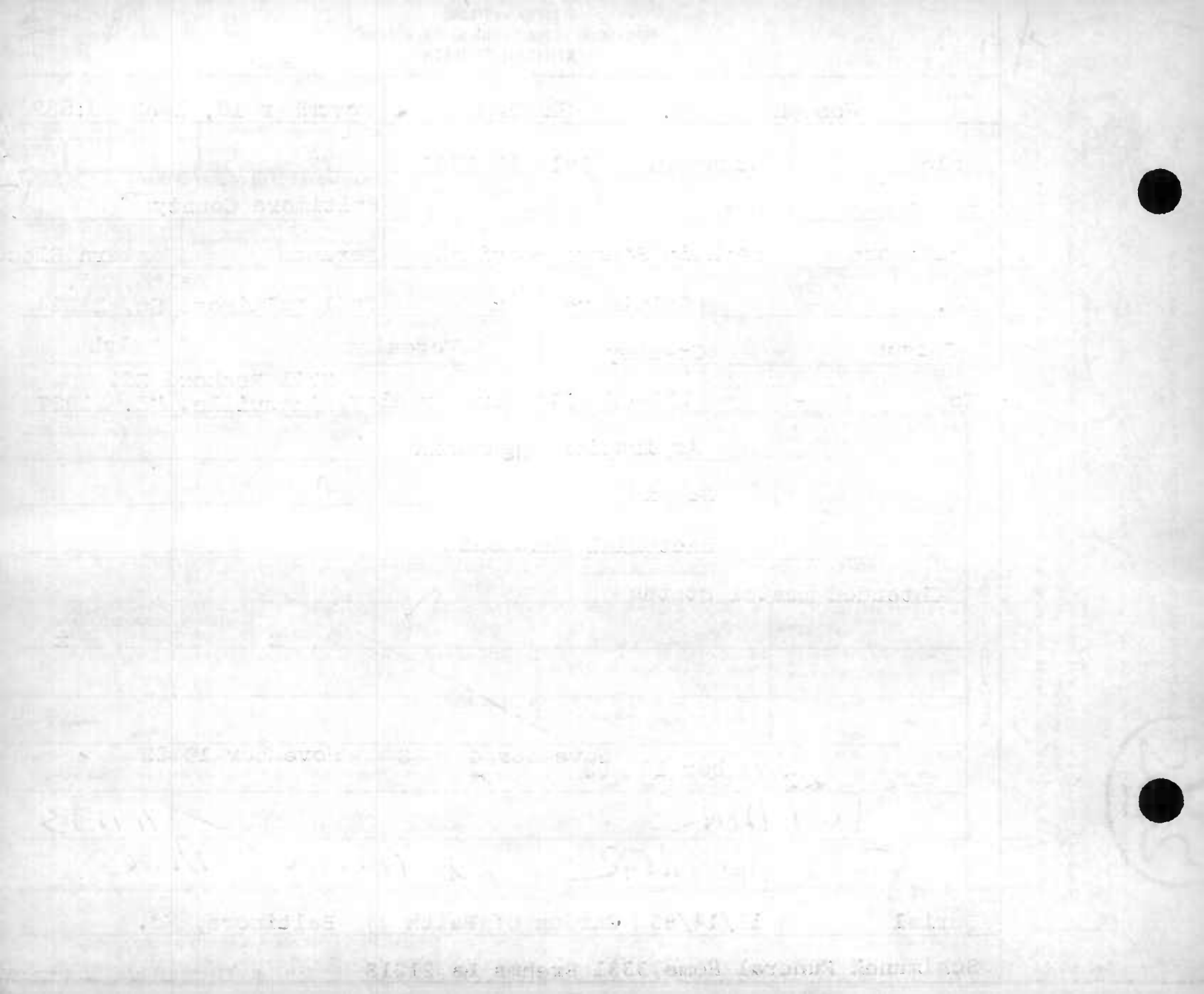
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please print name of physician retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   | REG. NO. |  |
|---|--|--|--|---|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>HILDA GREENBERG  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>SUN. NOV. 6, 1983   |          | 2b. HOUR<br>6:35AM   |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>AUG. 28, 1904  |          | 6. AGE (IN YEARS LAST BIRTHDAY)<br>79 YRS.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>BALTIMORE, MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |          | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |
| 10. CITY OR TOWN OF DEATH<br>PIKESVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>JEWISH CONVAL. NURSING CENTER   |  | 12a. USUAL OCCUPATION (IF OTHER THAN MAIN SOURCE OF WORKING LIFE)<br>HOUSEWIFE  |          | 12b. KIND OF BUSINESS OR INDUSTRY<br>HOME  |
| 13a. STATE<br>MARYLAND  |  |  |  | 13b. CITY<br>ANNAPOLIS  |          | 13c. STREET ADDRESS / ZIP CODE<br>18 PAROLE PLAZA (21401)  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JACOB SILVERMAN  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ANNIE POTTS   |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO   |  | 16b. SOCIAL SECURITY NO.<br>212-01-3630  |  | 17. INFORMANT ADDRESS<br>Mrs. Mace Silverman 18 Parole Plaza Annapolis, Md. (21401)   |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) <i>metastatic colon carcinoma</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Carcinoma of colon</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><i>ASCD</i>  |  |  |  |   |          |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |          | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |          |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> 19 <u>83</u> , to <u>11/6</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11/2</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                          |  |  |  |   |          |  |
| 22b. SIGNATURE<br><i>Stanley Rosen</i>  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/6/83   |          |  |
| 22d. PHYSICIAN'S NAME (PRINT)<br>STANLEY ROSEN  |  | 22e. ADDRESS<br>2435 W. BELVEDERE AVE. (21215)   |  | 22f. ADDRESS<br>2435 W. BELVEDERE AVE. (21215)  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>11/7/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>BETH HAMEDROSH HAGODOI  |          | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>ROSEDALE, BALTIMORE, MD.  |
| 24. FUNERAL DIRECTOR SOL LEVINSON & BROS.<br>NAME ADDRESS<br>6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 10 1983  |          |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |          |  |

BP

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JAN 10 1900

THE  
OFFICE OF THE  
SHERIFF

1900

1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |  |   |  |  |   |  |
|---|--|---|--|---|--|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO.   |  |   |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>August K. Gribbin</i>   |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11-5-83</i>                       |  |   | 2b. HOUR<br><i>8 p.m.</i>  |  |   |  |
| 3. SEX<br><i>Male</i>   |  | 4. RACE<br><i>Cauc.</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>Mar. 11 1897</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>86</i>   |   | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.              |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.                      |   |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Towson</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Stella Mairs Hospice</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Police inspector</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><i>Md.</i>  |  |   |  |   | 13b. COUNTY<br><i>Baltimore</i>  |  | 13c. CITY OR TOWN<br><i>Towson</i>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><i>John H. Gribbin</i>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Anna Annie J. Knell</i> |  |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>Unknown</i>   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><i>220-44-9622 A</i>                         |  | 17. INFORMANT ADDRESS<br><i>Stella Mairs Hospice Dulaney Valley Rd. Md.</i> |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>4370 Congestive Heart Failure</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterial Sclerotic Cerebral vascular disease</i><br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |  |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>11/5 1983</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)           |   |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11/5</i> , 19 <i>83</i> , to <i>11/5</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>11/5</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                      |  |   |  |   |  |  |   |  |  |   |  |
| 22b. SIGNATURE<br><i>Eddie Nakhuda, M.D.</i>  |  |   |  | DEGREE  |  |  |   | 22c. DATE SIGNED<br><i>11/5/83</i>                                     |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Eddie Nakhuda, M.D.</i>   |  |   |  | 22e. ADDRESS<br><i>Stella Mairs Hospice Dulaney Valley Rd Towson 21204</i>  |  |  |   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  |   |  | 23b. DATE<br><i>11-8-83</i>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Joseph's Cem.</i>                           |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Baltimore Md.</i>        |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>Lassahn Funeral Home</i>  |  |   |  | 24b. ADDRESS<br><i>7401 Belair Rd. Balto., Md. 21236</i>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 10 1983</i>                    |  |   |  |

11-2-3 84

August 11

Male

Crane

Mar. 11 1911

80

Baltimore County

Dr. J. B.

Harland

v

Stellman's Hospital

Townsend

Pollock's

Stellman's Hospital

Stellman's

Male

x

Knell

Stellman's

Stellman's

John

Stellman's Hospital

Townsend

Cardiac Heart Failure

Stellman's Hospital

11/2

11/2

11/2

11/10

11/2

11/2

11/2/13

x

Baltimore County

Stellman's Hospital

Stellman's Hospital

Stellman's Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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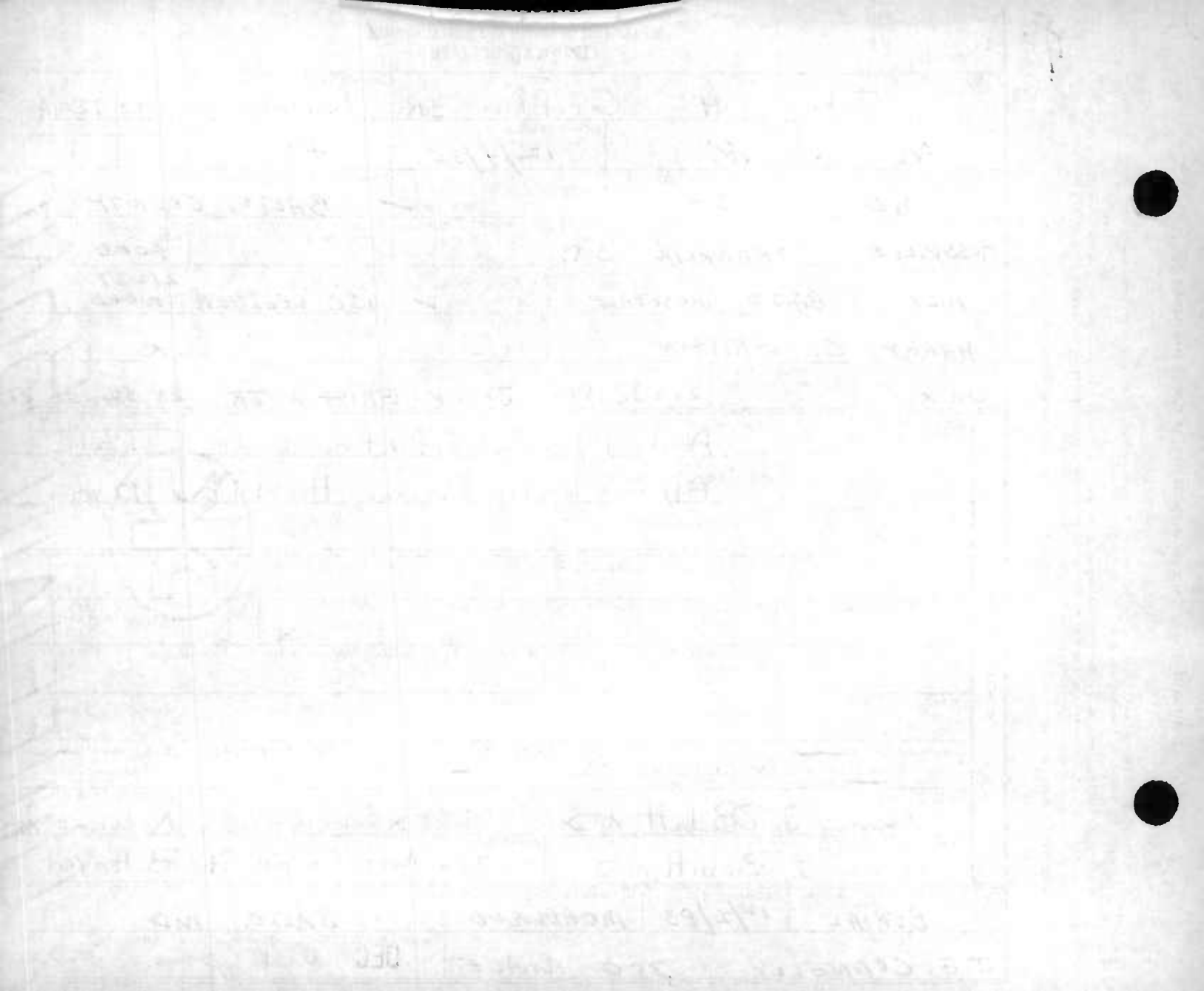
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |                           |  |                 |  |
|--|--|--|--|---|--|---|--|---------------------------|--|-----------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | 28. DATE OF DEATH  |  | MONTH   |  | DAY   |  | YEAR                      |  | 29. HOUR        |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  |  | MIDDLE  |  | LAST  |  | November 29, 1983         |  | 12:41 AM        |  |
| John   |  | H  |  | GRIFFIN   |  | SR  |  |                           |  |                 |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR           |  | IF UNDER 24 HRS |  |
| M  |  | W  |  | MONTH DAY YEAR<br>12/4/35   |  | 47  |  | MONTHS DAYS               |  | HOURS MIN.      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |                           |  |                 |  |
| MD.  |  | USA  |  |   |  | BALTO. COUNTY   |  |                           |  | MD.             |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |                           |  |                 |  |
| ROSSVILLE  |  | FRANKLIN SQ.   |  |   |  | FOOD  |  |                           |  |                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS       |  |                 |  |
| MD   |  | BALTO  |  | ROSEDALE  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 21237<br>15C LEATHER WOOD |  |                 |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |   |  |                           |  |                 |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  |   |  |   |  |                           |  |                 |  |
| HARRY C. GRIFFIN   |  | UNK  |  |   |  |   |  |                           |  |                 |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)  |  | 17. INFORMANT   |  | ADDRESS   |  |                           |  |                 |  |
| UNK  |  | 212321544  |  | JOHN GRIFFIN JR.  |  | 28 SHAWGO CT.   |  |                           |  |                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Atherosclerotic Coronary Heart Disease</u> 17 years<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>1 1/2 hours   |  |   |  |   |  |                           |  |                 |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |                           |  |                 |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                           |  |                 |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |                           |  |                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |                           |  |                 |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>March 27, 1978</u> , to <u>November 29, 1983</u> , that (I) (we) lost<br>saw the deceased alive on <u>November 23, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did not) view the body after death.   |  | 22b. SIGNATURE<br><u>Henry I. Babitt, M.D.</u><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><u>November 29, 1983</u>  |  |   |  |                           |  |                 |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Henry I. Babitt, M.D.</u>  |  | 22e. ADDRESS<br><u>2724 North Charles St. Balto, Md.</u>   |  |   |  |   |  |                           |  |                 |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>BURIAL</u>  |  | 23b. DATE<br><u>12/2/83</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>MORELAND</u>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>BALTO. MD.</u>     |  |                           |  |                 |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>J.G. COMVELLY</u>   |  | ADDRESS<br><u>300 MACE</u>   |  | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 6 1983</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>                    |  |                           |  |                 |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| FOR Item 19a&b & 22a film 586<br>1- STATE REGISTRAR 12-8-83 cn   |  |  |  |   |   |  |   |  |  |
| REG. NO. 28841   |  |  |  |   |   |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Alma L. Grim  |  |  |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>XII 11 01 83                                  |   | 2b. HOUR A<br>2:00 M   |  |
| 3. SEX<br>Female   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>03 04 15  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 YRS  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Meridian Nursing Center Catonsville |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>housewife        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>own home  |  |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE MD 13b. COUNTY Baltimore 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1024 Sharon Martin Ct. 21228                                  |  |  |  |   |   |  |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John Mills   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>? Speals   |   |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) No  |  |  |  | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS<br>Meridian Nursing Home Records                               |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Metastatic Disease<br>1749<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Stomach Masses<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |  |  |   |   |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)   |  |  |  |   |   |  |   |  |  |
| 19a. DATE OF OPERATION<br>1973   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-4-83, 19, to 11-2-83, 19, that (I) (we) lost saw the deceased alive on 10-4-83, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. Natural |  |  |  |   |   |  |   |  |  |
| 22b. SIGNATURE<br>George Anger   |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |   | 22c. DATE SIGNED<br>11-3-83  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>George Anger  |  |  | 22e. ADDRESS<br>Meridian Nursing Center  |   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>burial  |  |  | 23b. DATE<br>11/7/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Baltimore Md. |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Ambrose Funeral Home   |  |  |  |   |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 4 1983   |   | 26. REGISTRAR'S SIGNATURE<br>John J. Conner  |  |
| ADDRESS<br>1328 Sulphur Spring Rd.   |  |  |  |   |   |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2. DATE OF DEATH  |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>WILLIAM E. GUY, JR.</b>   |  |  |  | MONTH <b>11</b> DAY <b>17</b> YEAR <b>83</b> 2b. HOUR <b>11:46A</b>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>06</b> DAY <b>14</b> YEAR <b>13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Automotive</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Maryland</b> 13b. COUNTY <b>Baltimore</b> 13c. CITY OR TOWN <b>21234</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS<br><b>8412D Greenway Road 21234</b>     |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>William</b> MIDDLE <b>E.</b> LAST <b>Guy, Sr.</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Gladys</b> MIDDLE <b>V.</b> LAST <b>Bayne</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>215-03-9370</b>   |  | 17. INFORMANT ADDRESS<br><b>Katherine R. Guy 21234<br/>8412-D Greenway Rd.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4292 Cardiac Arrest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>10+ Years</b>         |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes mellitus</b>  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/1/73</b> to <b>11/17/83</b> , that (I) <del>last</del> <b>lost</b> saw the deceased alive on <b>11/16/83</b> , and that in (my) <del>last</del> <b>last</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>last</del> <b>last</b> (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Charles E. Shaw M.D.</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>11/17/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles E. Shaw, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>607 W. Joppa Road 21204</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov. 19, '83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Co., MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>William E. Johnson</b>  |  |  |  | 24a. DATE REC'D. BY REGISTRAR<br><b>NOV 18 1983</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Sam J. Conick</b>   |  |
| ADDRESS<br><b>8521 Loch Raven Blvd.</b>  |  |  |  |   |  |  |  |

BP



WILLIAM E. GUY, JR.  
MALE  
WHITE  
70  
BALTIMORE  
ST JOSEPH HOSPITAL  
BALTIMORE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |  |  |                                      |   |                                   |   |
|--|---|---|--|--|--------------------------------------|---|-----------------------------------|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   |   | 2a. DATE OF DEATH  |  |                                      | 2b. HOUR  |                                   |   |
| FIRST MIDDLE LAST<br>Ottillie Emma Hagestedt   |   |   | MONTH DAY YEAR<br>Nov. 7 1983  |  |                                      | M   |                                   |   |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |                                      | 7. IF UNDER 1 YEAR  |                                   |   |
| Female   | White   | MONTH DAY YEAR<br>March 13 1904   | 79 YRS.  |  |                                      | MONTHS DAYS HOURS MIN.  |                                   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |   |                                   |   |
| Germany  | Germany   |   |  |  | Balto. County MD.                    |   |                                   |   |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |                                      |   | 12b. KIND OF BUSINESS OR INDUSTRY |   |
| Freeland   | 2008 Bulls Saw Mill Rd.   |   |  | Homemaker  |                                      |   | -                                 |   |
| 13a. STATE   |   |   | 13b. COUNTY  |  |                                      | 13c. CITY OR TOWN   |                                   |   |
| Maryland   |   |   | Baltimore  |  |                                      | Freeland  |                                   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                          |  |                                      | 16. ADDRESS   |                                   |   |
| Heinrich Grote   |   |   | Dorothea Strauss   |  |                                      | 21053   |                                   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |   |   | 16b. SOCIAL SECURITY NO.   |  |                                      | 17. INFORMANT   |                                   |   |
| No   |   |   | 212-03-0796D   |  |                                      | Dorothy K. Walz, 2008 Bulls Saw Mill Rd.                                      |                                   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>4100 Suspected myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> |   |   |  |  |                                      |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>15 minutes</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Alzheimer's Disease</u>   |   |   |  |  |                                      |   |                                   |   |
| 19a. DATE OF OPERATION   |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |                                      | 20a. AUTOPSY?   |                                   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?    |
|  |   |   |  |  |                                      | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                                   | YES <input type="checkbox"/> NO <input type="checkbox"/>          |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |                                      | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |                                   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |                                      | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                                   |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>4/1</u> 19 <u>82</u> , to <u>11/1</u> 19 <u>83</u> , that (we) last saw the deceased alive on <u>10/24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.                             |   |   | 22b. SIGNATURE<br><u>Richard C. Habersat</u>                           |  |                                      | 22c. DATE SIGNED<br><u>11/17/83</u>   |                                   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   |   | 22e. ADDRESS   |  |                                      |   |                                   |   |
| Richard C. Habersat, M.D.  |   |   | Osler Medical Ctr., Towson, Md. 21204                                  |  |                                      |   |                                   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |   |   | 23b. DATE  |  |                                      | 23c. NAME OF CEMETERY OR CREMATORY  |                                   |   |
| Burial   |   |   | 11/9/83  |  |                                      | Lorraine Park Cem.  |                                   |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |   |   | 23e. DATE REC'D. BY REGISTRAR  |  |                                      | 23f. REGISTRAR'S SIGNATURE  |                                   |   |
| Woodlawn Balto. Md.  |   |   | NOV 21 1983  |  |                                      | <u>John J. Canfield</u>   |                                   |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |   |   | 24a. DATE REC'D. BY REGISTRAR  |  |                                      | 24b. REGISTRAR'S SIGNATURE  |                                   |   |
| J. E. Lowell Lemmon, 10 W. Padonia Rd.   |   |   | NOV 21 1983  |  |                                      | <u>John J. Canfield</u>   |                                   |   |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Pearl E Hall                                     |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 1 83 |   |  | 2b. HOUR<br>7:45 PM   |  |
| 3. SEX<br>female  |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 9 93   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>89   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia                                   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County 21222 MD.                              |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>225 Maple Avenue |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>house-wife                  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br>home   |  |   |  |   |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |  |   |  |   |  |   |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Dundalk  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Wood                                    |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Susan Wood   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no              |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  | 17. INFORMANT<br>Lois Walton 225 Maple Avenue 21222   |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5860

DUE TO, OR AS A CONSEQUENCE OF

(b) Renal failure

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 7, 19 83, to 11, 19 83, that (I) (we) lost<br>saw the deceased alive on 10, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br>David E. Grace  |  | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/2/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>DAVID E. GRACE MD  |  |  |  | 22e. ADDRESS<br>Baltimore City Hosp.   |  |   |  |

|  |  |                      |  |   |  |  |  |
|--|--|----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial               |  | 23b. DATE<br>11/4/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Prize Hill Cemetery |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Boonesville Virginia |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Walter Dabrowski 1005 Dundalk Avenue |  |                      |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 3 - 1983             |  | 25b. REGISTRAR'S SIGNATURE<br>James J. Smith                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND 8 3  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |   |   |  |  |
|---|--|--|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Arthur Elliott Hamilton</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 6 1983</b> |   |   | 2b. HOUR<br>M   |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Nov. 29 1920</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>                        |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Baltimore, Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD. |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Essex 21221</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1522 Barkley Rd.</b> |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Lithographer</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Printing</b>   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>1522 Barkley Rd. 21221</b>                |  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Essex 21221</b>   |   |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Athur E. Hamilton, Sr.</b>   |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Effie Stone</b>   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>WWII 216 10 4374</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Verna Hamilton, Wife Same</b>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cordiac Arrest</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Cordiac Arrhythmias</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Cardiovascular Disease</b> |  |  |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><b>Chronic Obstructive Pulmonary Disease</b>  |  |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October</b> , 19 <b>83</b> , to <b>Nov.</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>Nov. 4th</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |   |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Nina Okun</b>  |  |  |   | DEGREE  |   | 22c. DATE SIGNED<br><b>11/7/83</b>                                  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Nina Okun, M.D.</b>   |  |  |   | 22e. ADDRESS<br><b>9000 Franklin Square Dr.</b>   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>  |  | 23b. DATE<br><b>11/9/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>  |   | 23d. LOCATION<br><b>Baltimore Md.</b> COUNTY STATE                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Dr. J. J. Czuprynski</b><br><b>Czuprynski Funeral Home PA</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Wank</b>                   |  |  |

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |  |  |   |   |  |
|--|--|---|---|---|--|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Irene M Hamilton</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>11/22/83</b>                    |   |  | 2b. HOUR <b>4:19 AM</b>  |  |   |   |  |
| 3 SEX <b>Female</b>  |  | 4 RACE <b>Caucasian</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>6 30 87</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto. Co.</b> MD.   |  |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Armacost Nursing Home</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>Md.</b> 13b. COUNTY <input checked="" type="checkbox"/>  |  |   | 13c. CITY OR TOWN <b>Balto</b>                                      |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>1106 E. 36th St. Balto, Md. 21218</b>    |   |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Lemkuhl</b>   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Wooten</b>   |   |  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>  |  |   | 16b. SOCIAL SECURITY NO. <b>219-18-6368</b>                         |   | 17. INFORMANT ADDRESS <b>Balto, Md. 21239</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4292 IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arterio-sclerotic Cardiovascular Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Progressive over many years</b>                              |  |   |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 min</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cerebrovascular Accident; Cerebral arterio-sclerosis.</b>  |  |   |   |   |  |  |  |   |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>         |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |  |  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> 19 <b>82</b> , to <b>11/22</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>10/12</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |   |   |  |  |  |   |   |  |
| 22b. SIGNATURE <b>Edward J. Cotter</b>   |  |   | DEGREE  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c. DATE SIGNED <b>Nov 22, 1983</b>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward Cotter</b>   |  |   | 22e. ADDRESS <b>1900 Northern Parkway, Balto, Md.</b>               |   |  |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |   | 23b. DATE <b>11-25-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto., Maryland</b> |   |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Ruck Towson Funeral Home, Inc.</b>  |  |   | ADDRESS <b>1050 York Rd. Towson Md. 21204</b>                       |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>   |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1000 York Rd.  
Roch. Towson Trucking Co., Inc. Towson, Md. 21204

1000 York Rd.  
Roch. Towson Trucking Co., Inc. Towson, Md. 21204



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH28847  
REG. NO.FOR  
1 - STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |  |  |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Martha A. HAMPTON   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 30, 1983               |   |  | 2b. HOUR<br>6:17 am  |   |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>08 31 1893  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>90 YRS.   |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ILLINOIS  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQUARE HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>OWNER  |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>MOTEL   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |   |  |   |  |  |   |  |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>BALTIMORE  |  | 13c. CITY OR TOWN<br>ROSEDALE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 13e. STREET ADDRESS / ZIP CODE<br>7905 PULASKI HIGHWAY 21237   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>----- DUECKER  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>-----  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |   |  | 16b. SOCIAL SECURITY NO.<br>215037806   |  | 17. INFORMANT<br>ADDRESS<br>EVA HAMPTON 4003 PINEDALE DR.  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardiopulmonary Arrest<br>0389<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Sepsis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| MEDICAL CERTIFICATION  |  |   |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 19, PART 1 OR PART 2) |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |  |
| 22a. I certify that (this hospital) attended the deceased from November 29, 1983, to November 30, 1983, that (we) last saw the deceased alive on November 30, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (do not) view the body after death.  |  |   |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br>Allan Gittman  |  |   | DEGREE<br>M.D.   |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br>11/30/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Allan Gittman, M.D.   |  |   | 22e. ADDRESS<br>9000 Franklin Square Dr. Balto., MD 21237              |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>ENTOMBMENT  |  |   | 23b. DATE<br>12/2/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>LORRAINE PARK                            |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. BALTO. MD. |  |  |
| 24. FUNERAL DIRECTOR<br>J. J. [Signature]  |  |   | ADDRESS<br>1211 Chesapeake Ave. 21237                                  |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 1, 1983                                   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. [Signature]               |  |  |





ILLINOIS

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CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 28848   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>JOSHUA HANNA</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 83</b><br>2b. HOUR<br><b>5:30A</b> <sub>M</sub>   |  |  |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUC.</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3/21/07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b><br>IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b><br>MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>GBMC - 6701 N. CHARLES STREET</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Mechanic</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>County High-way Dept.</b>  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |  |   |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>White Hall</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Joshua J. Hanna</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Iva Miller</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>218-14-7798</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>1948 White Hall Rd.<br/>Margaret E. Hanna, White Hall, Md 21161</b>                         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>RESPIRATORY ARREST</b><br>IMMEDIATE CAUSE (a).<br><b>4349</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b).<br><b>BRAIN STEM INFARCTION</b><br>DUE TO, OR AS A CONSEQUENCE OF (c).<br><b>OLD CEREBRAL VASCULAR ACCIDENT</b><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/6</b> , 19 <b>83</b> , to <b>11/13</b> , 19 <b>83</b> , that (I) <input checked="" type="radio"/> saw the deceased alive on <b>11/13</b> , 19 <b>83</b> , and that in (my) <input checked="" type="radio"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="radio"/> did (I did not) view the body after death.   |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>   |  |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/13/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. CHARLES C. CUMMINGS, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>GBMC - 6701 N. CHARLES STREET</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Nov 16, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Vernon Cemetery</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Hall, Baltimore, MD</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. J. Hartenstein, Second at Franklin S</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR (b. REGISTRAR'S SIGNATURE)<br><b>NOV 17 1983</b><br><i>[Signature]</i>   |  |  |  |
| 25. ADDRESS<br><b>New Freedom, PA 17340</b>  |  |   |  |   |  |  |  |

BP

NO. 100,000,000

DATE: 1954 1 17

AMOUNT

AMOUNT

100,000,000

RECEIVED BY: [illegible]  
DATE: 1954 1 17



FOR THE PURPOSE OF: [illegible]

100,000,000

RECEIVED BY: [illegible]

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20% COTTON FIBRE

20% COTTON FIBRE



RECEIVED BY: [illegible]

RECEIVED BY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Bessie Elizabeth Hardy</b>   |  |   | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>20</b> YEAR <b>83</b> |  |  | 2b. HOUR <b>9:35 PM</b>   |  |
| 3 SEX <b>Female</b>   |  | 4. RACE <b>Cauc.</b>  |  | 5. DATE OF BIRTH MONTH <b>9</b> DAY <b>24</b> YEAR <b>96</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sandy Hook, Md</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto County</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Owings Mills</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Baptist Home of Md.</b>                           |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>store keeper</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>jewelry</b>  |  |
| 13a. STATE <b>Virginia</b>  |  | 13b. COUNTY <b>London</b>   |  | 13c. CITY OR TOWN <b>London Hgts</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST <b>Jacob</b> MIDDLE <b>S.</b> LAST <b>Lowery</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Albenta</b> MIDDLE <b>?</b> LAST <b>Quice</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES)  |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>212-01-2299</b>   |  | 17. INFORMANT ADDRESS <b>Rt. 1 Box 508 Purcellville, Va.</b>  |  |  |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Stroke C Hemiparesis / Aphasia</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSION</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: (c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTH</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>HYPOTHYROIDISM</b>  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (was hospital) attended the deceased from <b>Nov 17</b> 19 <b>83</b> to <b>Nov 20</b> 19 <b>83</b> , and that (I) (was) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>John T. Williams</b>  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11/21/83</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John T. Williams</b>   |  | 22e. ADDRESS <b>6805 York RD / BMT. MD 21212</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>11/23/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Park Hgts. Cemetery</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brownsville, Fred, Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>John T. Williams</b>   |  | ADDRESS <b>Funeral Home Brownsville, Md</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Ganiel</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten notes and calculations, including a table with columns for dates and values. The text is mostly illegible due to fading.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |  |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SADIE</b>   |  |  | FIRST MIDDLE LAST<br><b>HARRIS</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-15-83</b>   |  |  | 2b. HOUR<br><b>5-55P M</b>   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  |  | 4. RACE<br><b>WHITE</b>   |  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>AUG. 1, 1890</b>  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>ENGLAND</b>   |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |  | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>6906 DORSET PLA. 21215</b>  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ISAAC HERTZBACH</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LEAH UNKNOWN</b>  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-56-3303</b>   |  |  |
| 17. INFORMANT<br><b>MR. MELVIN M. HARRIS</b>  |  |  | 18. ADDRESS<br><b>6906 DORSET PLACE BALTO., MD 21215</b>  |  |  | 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4275 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 20 to</b><br><b>(b) Bacterial pneumonia and probable Aspiration</b><br><b>(c) pneumonia Dehydration.</b> |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Cystitis of throat</b>   |  |  |   |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-13</b> , 19 <b>82</b> , to <b>11-15</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-15</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>R.M. Shah, M.D.</b>  |  |  | DEGREE  |  |  | 22c. DATE SIGNED<br><b>11-15-83</b>  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R.M. SHAH.</b>  |  |  | 22e. ADDRESS<br><b>Baltimore County General Hospital RANDALLSTOWN, MD. 21133</b>  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>NOV. 17, 1983</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BNAI JACOB LODGE</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE COUNTY MARYLAND</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD., BALTO., MD 21215</b>  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1983</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. White</b>   |  |  |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>DAVID</b>  |  | FIRST<br><b>HARRISON</b>  |  | LAST<br><b>HARRISON</b>   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 21 / 83</b>                                  |  | 2b. HOUR<br><b>4:34 AM</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APR. 1, 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7219 PARK HTS. AVE., APT. 404</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EXECUTIVE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>ARCHITECTURE</b>           |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  | 13b. COUNTY<br><b>BALTO.</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>7219 PARK HTS. AVE. 21208</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>SIMON HARRISON</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ETTA SILVERMAN</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>214-18-9755A</b>   |  | 17. INFORMANT<br><b>MRS. ELSIE HARRISON</b>   |  | <b>APT. 404</b>   |  | <b>21208</b>   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Renal failure**

7531 DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) **chronic polycystic kidney disease**  
(c) **left renal tumor**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (c)

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>11/18</b> 19 <b>83</b> to <b>11/21</b> 19 <b>83</b> , that (I) <del>last</del> saw the deceased alive on <b>11/18</b> 19 <b>83</b> , and that in (my) <del>best</del> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Ralph Weber</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/21/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>RALPH WEBER, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>HOFFBERGER BLDG. - SINAI HOSP. - BALTO., MD</b>   |  |  |  |

|  |  |                              |  |   |  |  |  |
|--|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>                              |  | 23b. DATE<br><b>11/22/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hebrew Friendship</b>                                |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Joe Leunion + Bros</b> ADDRESS <b>6010 Reisterstown Rd</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 28 1983 John J. Connel</b> |  |  |  |

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |   |   |  |  |
|--|---|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR   |   | 2a. DATE OF DEATH   |   | 2b. HOUR   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |   | FIRST MIDDLE LAST   |   | MONTH DAY YEAR   |  |
| ELIZABETH H. HARRISON  |   | November 27, 1983   |   | 1:00 P.M.  |  |
| 3. SEX   | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE  | 7. IF UNDER 1 YEAR   |  |
| Female   | White   | Jan. 17, 1920   | 63 YRS.   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |
| Alabama  | USA   |   | Baltimore County MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| Owings Mills   | 37 Olive Lane   |   | Homemaker   |  | Own Home   |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |   |   |  |  |
| 13a. STATE   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS  |  |
| MD   | Balto.  | Owings Mills  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 37 Olive Lane 21117  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST                       |  |  |
| Emrys C. Harris  |   |   | Ellen P. Spears   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |
| No   |   | 216 52 2313   |   | Horace W. Harrison, Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u><br><u>4100</u> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HASCVD</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>18 hours</u><br><u>4 AM</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |   |   |   |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                 |
|  |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>MARCH 15, 1977</u> to <u>SUNDAY 4/27, 1983</u> , that (1) (we) last saw the deceased alive on <u>4/26, 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                             |   | 22b. SIGNATURE<br><u>John W. Williams</u>   |   | 22c. DATE SIGNED<br><u>11/28/83</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |   |  |  |
| Dr. McRae Williams, M.D.   |   | Union Memorial Hospital, Balto., MD   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |
| Cremation  | 11/28/83  | Green Mount   | Balto., MD  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS   |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |
| Henry W. Jenkins & Sons Co.<br>4905 York Road Balto., MD 21212   |   | NOV 28 1983   |   | <u>John J. Connel</u>  |  |

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## References

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 2 8 8 5 3   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | REG. NO.  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>IRENE B. HARRISON</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 18 83</b>   |  | 2b. HOUR<br><b>9:04</b> M  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 23 1896</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>CATONSVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUMMIT NURSING HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>---</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>---</b>  |  | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM COLLETT</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>KATIE BURNS</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-22-6667</b>   |  | 17. INFORMANT ADDRESS<br><b>CHARLES R. HARRISON 2930 WOODWICK COURT ELLICOTT CITY, MD.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4273 Congestive Heart Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atrial Fibrillation</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>1. Emphysema 2. Mental psychosis</b>   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>October 31, 1983</b> to <b>Nov. 18, 1983</b> , that (I) (we) lost saw the deceased alive on <b>Nov. 17, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>James E. Rowe</b>  |  |  |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>Nov. 18, 83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES E. ROWE, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>413 COMMONWEALTH AVENUE, 21228</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>11-21-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTIMORE CITY MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>HUBBARD FUNERAL HOME, INC.</b>  |  |  |  | ADDRESS<br><b>4107 WILKENS AVE. 21229</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1983</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>James E. Rowe</b>  |  |  |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. **IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate filed with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |  |  | 28854 |  |
|--|--|---|--|---|--|--|--|--|--|-------|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |   |  |  |  |  |  |       |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM MELVIN HARRISON</b>  |  |   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 25 83</b>                               |  | 2b. HOUR<br><b>3:52 PM</b>   |  |       |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>03 07 11</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>72</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 0 0 0</b>   |  |       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>                  |  |  |  |       |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>(GBMC) 6701 NORTH CHARLES STREET</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Steam Fitter</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Local 438</b>  |  |       |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>7734 Washington Blvd. 21227</b>                 |  |  |  |       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard Harrison</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Nellie Sullivan</b>   |  |  |  |  |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>A 213-09-0636</b>  |  | 17. INFORMANT<br><b>7734<sup>5</sup> Washington Blvd. Balto., MD. 21227</b>          |  |  |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>1629</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC LUNG &amp; CANCER</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 MONTHS</b> |  |   |  |   |  |  |  |  |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |  |  |  |       |  |
| 19a. DATE OF OPERATION<br><b>8-22-83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>LUNG CANCER</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 11-4 19 83</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)<br><b>NO INJURY</b>  |  |  |  |  |  |       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>7801 YORK RD. DORSEY HOWARD MARYLAND</b>  |  | 22c. DATE SIGNED<br><b>11-25-83</b>  |  |  |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-4 19 83</b> to <b>11-25 19 83</b> , that (I) (we) last saw the deceased alive on <b>11-25 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |       |  |
| 22b. SIGNATURE<br><i>Ken Murray</i>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>11-25-83</b>  |  |       |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>KEN MURRAY, MD</b>   |  |   |  | 22e. ADDRESS<br><b>7801 YORK RD. 21204</b>  |  |  |  |  |  |       |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/29/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Dorsey Howard Maryland</b>          |  | 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1983</b>  |  |       |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Duda-Ruck, Inc. 7922 Wise Avenue Dundalk, MD. 21222</b>   |  |   |  |   |  |  |  |  |  |       |  |
| 25. REGISTRAR'S SIGNATURE<br><i>John J. Lohr</i>   |  |   |  |   |  |  |  |  |  |       |  |

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701 NORTH CHAMBER STREET

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LONG CANON

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NO INJURY

11-11

11-11

11-22-13

701 NORTH CHAMBER STREET

NO INJURY

NEW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   |  | REG. NO. 28855  |   |
|--|---|---|---|--|---|---|
| 1. DECEASED NAME (TYPE OR PRINT)<br>OWEN G. HARTLOVE   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>11-23-1983                                |  | 2b. HOUR<br>6:30AM                                      |   |
| 3. SEX<br>MALE   | 4. RACE<br>WHITE  | 5. DATE OF BIRTH MONTH DAY YEAR<br>8 2 1902   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.                                    |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MD.   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTO. County MD.                     |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST. JOSEPH HOSPITAL |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OR WORKING LIFE)<br>Manufacturer |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Chemical           |   |
| 13a. STATE<br>md.  |   | 13b. COUNTY<br>Baltimore  | 13c. CITY OR TOWN<br>Baltimore  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br>38F HANBROOKE CT.                |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Owen A. Hartlove  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Lillian V. Griffin              |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |   | 16b. SOCIAL SECURITY NO.<br>215-07-4492   | 17. INFORMANT ADDRESS<br>(Hospital chart.)                                    |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Brain Stem infarction<br>4349<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a   |   |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 - PART I OR PART 2)              |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                  |   |   |   |  |   |   |
| 22b. SIGNATURE<br>L. House   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |   | 22c. DATE SIGNED   |   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>L. House  |   | 22e. ADDRESS  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |   | 23b. DATE<br>11/26/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cem.                                       |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore, Md.   |
| 24. FUNERAL DIRECTOR NAME<br>MITCHELL-WIEDEFELD HOME, INC.   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>DEC 01 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Conner  |
| ADDRESS<br>6500 York Road  |   |   |   |  |   |   |

BP



From 27th September

*Approved*

20% COTTON

X

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO.

1 - FOR  
 STATE  
 REGISTRAR

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HENRY HARTMAN</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Nov. 18, 1983</b>  |   | 2b. HOUR<br>M  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>5 11 1916</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>67</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE Co</b> MD.  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>7301 Kirtley Rd.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD.</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>DUNDALK</b> |  |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>7301 KIRKLEY RD.</b> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>WILLIAM HARTMAN</b>  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>VICTORIA WISNIEWSKI</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>217 078162</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>GENEVIEVE HARTMAN 7301 KIRKLEY RD.</b> |  |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arterio sclerotic Cardiovascular Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>74 years</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

|  |                                |  |  |  |  |
|--|--------------------------------|--|--|--|--|
| 19a. DATE OF OPERATION   |                                | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                                | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12-8</b> , 19 <b>76</b> , to <b>11-18</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>9-1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (A) (we) (and) (dis) view the body after death. |                                |  |  |  |  |
| 22b. SIGNATURE<br><b>Larry G. Tilley</b> MD  |                                | DEGREE   |  | 22c. DATE SIGNED<br><b>11/21/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>LARRY G. TILLEY</b>  |                                | 22e. ADDRESS<br><b>1212 OLD NORTH POINT RD<br/>BALTIMORE, MD 21224</b> |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   | 23b. DATE<br><b>11-22-1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b>               |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b>              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b>  |                                | ADDRESS<br><b>2525 FLEET ST</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1983</b>                            | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 28852   |   |
|--|--|--|--|--|---|
| FOR<br>1. STATE REGISTRAR  |  |  |  |  |   |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BESSIE E. HASLUP</b>   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>Nov. 29, 1983</b>  |  | 2b. HOUR <b>M</b>   |
| 3. SEX <b>Female.</b>  | 4. RACE <b>Cau.</b>  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 8, 1895</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Balto Co.</b> MD.                                    |  |   |
| 10. CITY OR TOWN OF DEATH <b>Towson.</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Ruxton.</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>-----</b>                   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>BALTO</b>  |  | 13c. CITY OR TOWN <b>Balto.</b>  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>3514 Lynchester Rd.</b> 21215  |
| 14. FATHER'S NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>?</b> MIDDLE <b>?</b> LAST <b>?</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>-----</b>   |  | 16b. SOCIAL SECURITY NO. <b>215-42-6906</b>  | 17. INFORMANT ADDRESS <b>Elaine H. Herring, 3514 Lynchester Rd.</b>                          |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1590</b> IMMEDIATE CAUSE (a) <b>TERMINAL CA. OF BOWEL</b>   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| DUE TO, OR AS A CONSEQUENCE OF (b) <b>1590</b>   |  |  |  |  |   |
| DUE TO, OR AS A CONSEQUENCE OF (c) <b>1590</b>   |  |  |  |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1590</b>  |  |  |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/27/83</b> , 19 <b>83</b> , to <b>11/29/83</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/27/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE <b>CELIA E. PARRA</b>   |  | DEGREE   |  | 22c. DATE SIGNED <b>11/30/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CELIA E. PARRA</b>  |  | 22e. ADDRESS <b>7122 HARFORD ROAD BALTIMORE, MD. 21234</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation.</b>  |  | 23b. DATE <b>Dec. 1, 1983</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>   |
| 24. FUNERAL DIRECTOR NAME <b>Paul E. Chenoweth</b>   |  | ADDRESS <b>3615-19 Chestnut Ave.</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>DEC 2 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b> |   |

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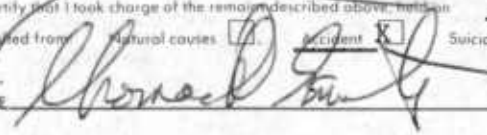

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5. PAGES 1, 2, AND 3 SHOULD BE FILED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |                      |  |   |  |   |  |  |                         | REG. NO. 8850  |  |
|---|--|----------------------|--|---|--|---|--|--|-------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Sandra Jean Hawkins</b>  |  |                      |  |   |  |   | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>14</b> YEAR <b>1983</b> |  | 2b. HOUR <b>6:22 PM</b> |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>white</b> |  | 5. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>24</b> YEAR <b>1958</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b> YRS.  |  | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>  |                         | 2c. DATE PRONOUNCED DEAD <b>11 14 1983</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>   |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                         | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore County, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Pikesville</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2100 Blk. Smith Avenue</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Med. Technican</b>  |                         | 12b. KIND OF BUSINESS OR INDUSTRY <b>Cat. Research</b>   |  |
| 13a. STATE <b>Md</b>  |  |                      |  | 13b. COUNTY <b>-</b>  |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                         | 13e. STREET ADDRESS <b>5947 Western Park Drive 21209</b>   |  |
| 14. FATHER'S NAME<br>FIRST <b>James S.</b> MIDDLE <b>Hawkins</b> LAST <b></b>   |  |                      |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Gwendolyn</b> MIDDLE <b>Leaf</b> LAST <b></b>  |  |  |                         |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>  |  |                      |  | 16b. SOCIAL SECURITY NO. <b>212 74 5133</b>   |  | 17. INFORMANT ADDRESS <b>Gwendolyn Leaf 5518 Mattfelt Avenue 21209</b>  |  |  |                         |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>8150</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b> |  |                      |  |   |  |   |  |  |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |                      |  |   |  |   |  |  |                         |  |  |
| 19a. DATE OF OPERATION  |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  |  |                         | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY<br>HOUR <b>6:15 PM</b> MONTH <b>11</b> DAY <b>14</b> YEAR <b>1983</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver in auto/fixed object impact</b>   |  |  |                         |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>street</b>   |  | 21f. LOCATION<br>STREET <b>2100 Blk. Smith Ave,</b> CITY OR TOWN <b>Pikesville,</b> COUNTY <b>Balto.,</b> STATE <b>Md</b> |  |  |                         |  |  |
| 22a. I certify that I took charge of the remains described above, held on death resulted from <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |  |                      |  |   |  |   |  |  |                         | Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion |  |
| ACTUAL SIGNATURE   |  |                      |  | TITLE (SPECIFY) <b>Deputy Chief</b>   |  |   |  | DATE SIGNED <b>11/15/83</b>  |                         |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>  |  |                      |  | ADDRESS <b>111 Penn St. Balto., MD.</b>   |  |   |  |  |                         |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |                      |  | 23b. DATE <b>11/18/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>  |  | 23d. LOCATION<br>CITY OR TOWN <b>Fullerton</b> COUNTY <b>Balto. Co.</b> STATE <b>Md</b>  |                         |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Burgee Funeral Home</b> ADDRESS <b>3631 Falls Road 21211</b>  |  |                      |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 16 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE    |                         |  |  |



*[Faint, illegible handwritten signature or text]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |                   |   |    |   |    |  |         |  |  |            |  |
|---|--|--|-------------------|---|----|---|----|--|---------|--|--|------------|--|
| 1. FOR STATE REGISTRAR  |  |  | REG. NO.          |   |    |   |    |  |         |  |  |            |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  | 2a. DATE OF DEATH |   |    | MONTH   |    | DAY  |         | YEAR   |  | 2b. HOUR   |  |
| John T. Hayes   |  |  | 11                |   | 19 |   | 83 |  | 10:00AM |  |  |            |  |
| 3. SEX  |  | 4. RACE  |                   | 5. DATE OF BIRTH  |    | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |    | IF UNDER 1 YEAR  |         | IF UNDER 24 HRS.                             |  |            |  |
| Male  |  | White  |                   | MONTH DAY YEAR<br>02 15 15  |    | 68 YRS.   |    | MONTHS   |         | DAYS   |  | HOURS MIN. |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |                   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |    | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |    |  |         |  |  |            |  |
| Maryland  |  | U.S. A.  |                   |   |    | Baltimore County MD.  |    |  |         |  |  |            |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |                   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |    | 12b. KIND OF BUSINESS OR INDUSTRY                                   |    |  |         |  |  |            |  |
| Catonsville   |  | Meridian-Catonsville   |                   | Retired Personnel   |    | Westinghouse  |    |  |         |  |  |            |  |
| 13a. STATE  |  | 13b. COUNTY  |                   | 13c. CITY OR TOWN   |    | 13d. INSIDE CITY LIMITS?  |    | 13e. STREET ADDRESS  |         |  |  |            |  |
| Maryland  |  | Baltimore  |                   | Catonsville   |    | YES <input type="checkbox"/> NO <input type="checkbox"/>            |    | 1916 Beverly Road  |         | 21228  |  |            |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |                   |   |    |   |    |  |         |  |  |            |  |
| FIRST MIDDLE LAST<br>John T. Hayes  |  | FIRST MIDDLE LAST<br>Margaret Mills  |                   |   |    |   |    |  |         |  |  |            |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |                   | 17. INFORMANT   |    | ADDRESS   |    |  |         |  |  |            |  |
| Yes   |  | WW 2   |                   | 212-03-0781A  |    | Mrs. Marian L. Hayes  |    | Same as # 13   |         |  |  |            |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ASCVD C A-FIB</u><br><u>4292</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>CHF</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>PNEUMONITIS</u> |  |  |                   |   |    |   |    |  |         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |            |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |  |                   |   |    |   |    |  |         |  |  |            |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                   |   |    | 20a. AUTOPSY?   |    | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |         |  |  |            |  |
|   |  |  |                   |   |    | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |    | YES <input type="checkbox"/> NO <input type="checkbox"/>       |         |  |  |            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |                   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |    |   |    |  |         |  |  |            |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                 |                   | 21f. LOCATION<br>STREET   |    | CITY OR TOWN  |    | COUNTY   |         | STATE  |  |            |  |
|   |  |  |                   |   |    |   |    |  |         |  |  |            |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>83</u> , to <u>11/19</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>10/18</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. If (we) (I) (do) (do not) view the body after death.          |  |  |                   |   |    |   |    |  |         |  |  |            |  |
| 22b. SIGNATURE  |  |  |                   |   |    | DEGREE  |    | 22c. DATE SIGNED   |         |  |  |            |  |
| <u>John H. Shaw</u>   |  |  |                   |   |    |   |    | 11/19/83   |         |  |  |            |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |                   |   |    | 22e. ADDRESS  |    |  |         |  |  |            |  |
| DR JOHN H. SHAW   |  |  |                   |   |    | 5800 Edmondson Ave  |    |  |         |  |  |            |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |                   | 23c. NAME OF CEMETERY OR CREMATORY  |    | 23d. LOCATION<br>CITY OR TOWN                                       |    | COUNTY   |         | STATE  |  |            |  |
| Burial  |  | 11/22/83   |                   | Woodlawn Cemetery   |    | Woodlawn  |    |  |         | Md.  |  |            |  |
| 24. FUNERAL DIRECTOR<br>Leroy M. & Russell C. Witzke Funeral Homes P.A.<br>1630 Edmondson Avenue, Catonsville, Md. 21228  |  |  |                   |   |    | 25a. DATE REC'D. BY REGISTRAR                                       |    | 25b. REGISTRAR'S SIGNATURE                                     |         |  |  |            |  |
|   |  |  |                   |   |    | NOV 21 1983   |    | <u>John J. Smith</u>   |         |  |  |            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |                              |   |  |  |   |   |  |  |
|---|--|------------------------------|---|--|--|---|---|--|--|
| 1. FOR STATE REGISTRAR  |  |                              | REG. NO.  |  |  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                              | FIRST MIDDLE LAST   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR                                    |   |  | 2b. HOUR                                     |
| MARIE MARGARET HEAPS  |  |                              |   |  |  | November 25, 1983   |   |  | 3:25 P <sub>M</sub>                          |
| 3. SEX  |  | 4. RACE                      |   | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |   | 7. IF UNDER 1 YEAR   |  |
| Female  |  | White                        |   | August 6, 1920   |  | 63  |   | MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |  |  |
| Maryland  |  | USA                          |   |  |  | Baltimore County MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |
| Parkton   |  |                              | 2422 Bond Road  |  |  | Housewife   |   | Own Home   |  |
| 13a. STATE  |  |                              | 13b. COUNTY   |  | 13c. CITY OR TOWN  |   | 13d. INSIDE CITY LIMITS?  |  |  |
| Maryland  |  |                              | Baltimore   |  | Parkton  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME   |  |                              | 15. MOTHER'S MAIDEN NAME  |  |  | 13e. STREET ADDRESS   |   |  |  |
| FIRST MIDDLE LAST   |  |                              | FIRST MIDDLE LAST   |  |  | 2422 Bond Rd., 21120  |   |  |  |
| Clarence Matthews   |  |                              | Mary Founds   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |                              | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |   |   |  |  |
| no  |  |                              | 216-28-8329   |  | 2422 Bond Rd.<br>Larry D. Heaps, Parkton, MD 21120                             |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory</u><br><u>1844</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Progressive Vulvar cancer</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u><br>DUE TO, OR AS A CONSEQUENCE OF |  |                              |   |  |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>  |  |                              |   |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |                              |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
|   |  |                              |   |  |  |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>83</u> , to <u>October</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>October</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                             |  |                              |   |  |  |   |   |  |  |
| 22b. SIGNATURE  |  |                              |   |  | DEGREE   |   | 22c. DATE SIGNED  |  |  |
| <u>Nat B. Rosenheim</u>   |  |                              |   |  |  |   | 11/25/83  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE PRINTS)   |  |                              |   |  | 22e. ADDRESS   |   |   |  |  |
| <u>Nat B. Rosenheim</u>   |  |                              |   |  | <u>The Johns Hopkins Hospital</u>  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |                              | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION   |  |  |
| Burial  |  |                              | Nov. 28, 1983   |  | Norrisville Cemetery   |   | White Hall, Harford, MD   |  |  |
| 24. FUNERAL DIRECTOR  |  |                              |   |  | 25a. DATE REC'D. BY REGISTRAR  |   | 25b. REGISTRAR'S SIGNATURE  |  |  |
| J. O. Hartenstein, New Freedom, PA  |  |                              |   |  | DEC 9 1 1983   |   | <u>John J. Smith</u>  |  |  |

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |   |   |  |  |
|--|--|--|--|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>EMMA C. HEDDERICK</b>   |  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>18</b> YEAR <b>83</b> |   |   | 2b. HOUR <b>M</b>   |  |  |
| 3. SEX <b>F</b>  |  | 4. RACE <b>W</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>3</b> DAY <b>1</b> YEAR <b>1913</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS. <b>70</b>  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>COUNTY - BALTO</b> MD.                               |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MERIDIAN NRSG. CTR. - HERITAGE</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HSWE</b>                 |  |  |
| 13a. STATE <b>MD</b>   |  | 13b. COUNTY <b>BALTO</b>   |  | 13c. CITY OR TOWN <b>DUNDALK</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>FIRST <b>HARRY</b> MIDDLE <b>NUCE</b> LAST <b></b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>IDA</b> MIDDLE <b>MAE</b> LAST <b>GRANIGAN</b>  |  |   |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212 10 4929</b>   |  | 17. INFORMANT ADDRESS<br><b>JAMES ANGEL 3 CLIPPER RD</b>  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute CVA</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Advanced Arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Cardiomegaly</b> |  |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>Anemia</b>   |  |  |  |   |   |   |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |   |  |  |
| 22b. SIGNATURE<br><b>Dr. Patricio</b>  |  |  |  | DEGREE<br><b>MD</b>   |   | 22c. DATE SIGNED<br><b>11/18/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. PATRICIO - 276-7714</b>  |  |  |  | 22e. ADDRESS  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>11/21/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LODGE PARK</b>   |   | 23d. LOCATION<br>CITY OR TOWN <b>BALTO</b> COUNTY <b>MD.</b> STATE                              |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>J.G. CONNELLY</b> ADDRESS <b>300 MACE</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelly</b>   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.)



UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535

11 16 81

MEMORANDUM

2

DATE

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

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SUBJECT: [Illegible]

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424

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11/16/81

RE: [Illegible]

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|   |  |  |   |   |  |  |   |   |  |  |
|---|--|--|---|---|--|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Luisa A. HEISER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 24, 1983</b>     |   |  | 2b. HOUR<br><b>12:55AM</b>   |   |   |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 18, 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS                                 |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>PUERTO RICO</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.              |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>ESSEX</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SQUARE HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>CLERK</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>G. L. MARTIN</b>        |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |  |  | 13b. COUNTY<br><b>BALTIMORE</b>                                     |   | 13c. CITY OR TOWN<br><b>PARKVILLE</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS / ZIP CODE<br><b>7303 PARK DRIVE 21234</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ALFREDO SANTANA</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARIA LOPEZ</b> |   |  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |  |  | 16b. SOCIAL SECURITY NO.<br><b>21826 0029</b>                       |   | 17. INFORMANT<br><b>FAMILY RECORDS</b> |  | ADDRESS   |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardio-Respiratory Arrest, Aspiration**4275  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

**Pneumonia**

(b) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (x) (this hospital) attended the deceased from <b>November 23, 1983</b> to <b>November 24, 1983</b> , that (x) (we) last saw the deceased alive on <b>November 24, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Dr. Waclaw Kazimierczak</i>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-24-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. Waclaw Kazimierczak, MD</b>  |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>   |  |   |  |

MEDICAL CERTIFICATION

|   |  |                                   |  |   |  |  |  |
|---|--|-----------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>Nov. 28, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Mem. Park</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>PARKVILLE BALTO. MARYLAND</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Evans Chapel</b>           |  |                                   |  | ADDRESS<br><b>8800 DEPT. MARIUS HARFORD RD.</b>                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1983</b>                             |  |
|   |  |                                   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conner</i>                            |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

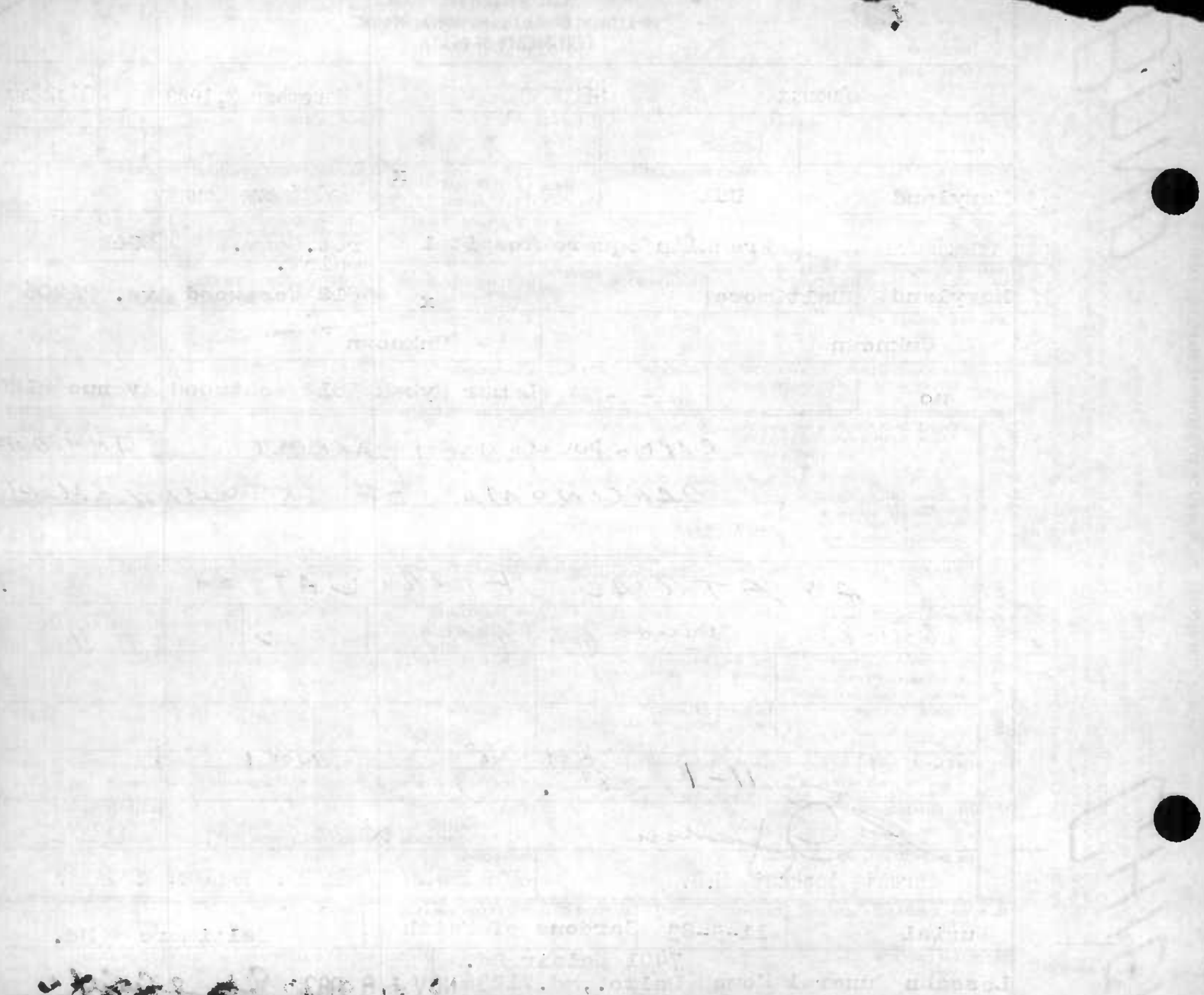
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |   |   |  |  |  |   |  |
|--|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>August HELBERG  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 2, 1983         |   |  | 2b. HOUR<br>11:22am  |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 9 09   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>ret. Serv. & maint.                                    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>BG&E                           |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Baltimore  |   | 13c. CITY OR TOWN<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE<br>5812 Westwood Ave. 21206   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Unknown  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Unknown        |   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>no                      |  |   |  |
| 16a. SOCIAL SECURITY NO.<br>212-05-3672  |  |   | 17. INFORMANT ADDRESS<br>Lamar Rybak 5812 Westwood Avenue 21206 |   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u><br>1519<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>CARCINOMA OF STOMACH</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>AT ATRIAL FIBRILLATION</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>IMMEDIATE</u><br><u>3 MONTHS</u> |  |   |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br>8-11-83  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of STOMACH  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-11-83</u> , 19 <u>83</u> , to <u>NOV 2</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-8</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                     |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>E. E. Ebrahim</u>   |  |   |   | DEGREE  |  | 22c. DATE SIGNED<br>11/3/83  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Ebrahim Ipakchi, M.D.   |  |   |   | 22e. ADDRESS<br>8019 PHILADELPHIA RD. BALTO., MD 21237  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>11-5-83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gardens of Faith  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Md.  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Lassahn Funeral Home   |  | ADDRESS<br>7401 Belair Rd.<br>Balto., Md. 21236   |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1983   |  |  |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>George C. Smith</u>   |  |   |   |   |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/B1  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |  |                            |  |
|--|--|---|---|--|----------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Mary Ella Hendricks</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 19, 1983</b> |  | 2b. HOUR<br><b>6:10 PM</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>October 14, 1892</b>  |                            |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>YRS.  |   | IF UNDER 24 HRS.<br>HOURS MIN.   |                            |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |                            |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b>  |  | 10. CITY OR TOWN OF DEATH<br><b>Baltimore</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Meridian Nursing Home</b>  |                            |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Secretary</b>   |   | 13a. STREET ADDRESS<br><b>16 Fusting Ave., 21228</b>   |                            |  |
| 13b. STATE<br><b>Maryland</b>  |  | 13c. CITY OR TOWN<br><b>Catonsville</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>late Harry Banks</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>late Margaret Buck</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |                            |  |
| 16b. SOCIAL SECURITY NO.<br><b>215 16 9596</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs John Arledge 9421 Old Frederick Rd Ellicott City, 21043</b>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4960 Anteroclostridium Clostridium Vass. disease</b><br>IMMEDIATE CAUSE (a) <b>4960</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>CD PD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |                            |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                            |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER) |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>5-1-19-79</b>  |                            |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |                            |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 22a. SIGNATURE<br><b>HARRY H. WITZKE MD</b>   |   | 22b. ADDRESS<br><b>5411 Old Frederick Rd Ellicott City</b>   |                            |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>HARRY H. WITZKE MD</b>   |  | 22d. ADDRESS<br><b>5411 Old Frederick Rd Ellicott City</b>  |   | 22e. DATE SIGNED<br><b>11/21/83</b>  |                            |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov 23, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>   |                            |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry H Witzke 4112 Columbia Rd Ellicott City</b>  |   | 25. DATE REC'D. BY REGISTRAR (SEAL) REGISTRAR'S SIGNATURE<br><b>NOV 22 1983 John J. Canineh</b>  |                            |  |

MEDICAL CERTIFICATION



HARRY H. WICKS, 1112 Columbia St. ELICOTT CITY  
Nov 13, 1983 London Park  
Baltimore Maryland

late HARRY Banks  
Maryland Baltimore  
late MARGARET Bank  
Baltimore  
Meridian Nursing Home  
Baltimore  
Secretary  
Baltimore County  
October 14, 1983  
November 18, 1983

315 16 9590 Mrs John Albridge 9211 Old Frederick Rd  
MILFORD CITY 21043



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sealed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  | 2a. DATE OF DEATH   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>REBA M. HENDRIX  |  |   |  | MONTH DAY YEAR<br>11 30 '83   |  | 2b. HOUR<br>4:30A <sub>M</sub>   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4 25 02   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>GBMC-6701 N. CHARLES ST. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Own Home  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Glen Arm  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS<br>13224 Dulaney Valley Rd. 21057  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>James Brose   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Fannie Belle Gemmill Rd.   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) no   |  | 16b. SOCIAL SECURITY NO.<br>212-32-4939   |  | 17. INFORMANT<br>ADDRESS<br>Paul R. Hendrix, 13224 Dulaney Valley Glen Arm, MD 21057  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIAC ARREST<br>4148 } DUE TO, OR AS A CONSEQUENCE OF<br>COMPLET HEART BLOCK DUE TO<br>(b) MYOCARDIAL INFARCTION<br>(c) DUE TO, OR AS A CONSEQUENCE OF                 |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                    |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                          |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)              |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/30 83, to 11/30 83, that (I) (we) last saw the deceased alive on 11/30 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Mary Ann D. Moore M.D.  |  |   |  | DEGREE<br>M.D.  |  | 22c. DATE SIGNED<br>11/30/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARY ANN D. MOORE, M.D.  |  |   |  | 22e. ADDRESS<br>GBMC-6701 N. CHARLES ST.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Dec 2, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>New Freedom Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>New Freedom, York, PA  |  |
| 24. FUNERAL DIRECTOR<br>J. J. Hartenstein, New Freedom, PA 17349  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>DEC 14 1983  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |   |  |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CAROLINE HENRY</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-7-83</b> |   |  | 2b. HOUR<br><b>9:22</b><br>A M  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MAY 15, 1890</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOUSEWIFE</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>      |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>912 MILFORD MILL RD. 21208</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>GUSTAV BAER</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>SOPHIE UNKNOWN</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>112-18-4693</b>  |  | 17. INFORMANT <b>JACOB GERSH</b> ADDRESS<br><b>912 MILFORD MILL RD. BALTO., MD 21208</b>        |  |  |  |

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  | (b) <b>arteriosclerotic heart disease with heart failure</b><br>(c) <b>peripheral vascular thrombosis</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.

MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>10-17-1983</b> to <b>11-7-1983</b> , that (I) (we) lost saw the deceased alive on <b>11-7-1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Soonchul Hong</b>  |  |  |  | DEGREE   |  | 22c. DATE SIGNED<br><b>11-7-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOONCHUL HONG</b>   |  |  |  | 22e. ADDRESS<br><b>Baltimore County General Hospital</b>                       |  |  |  |

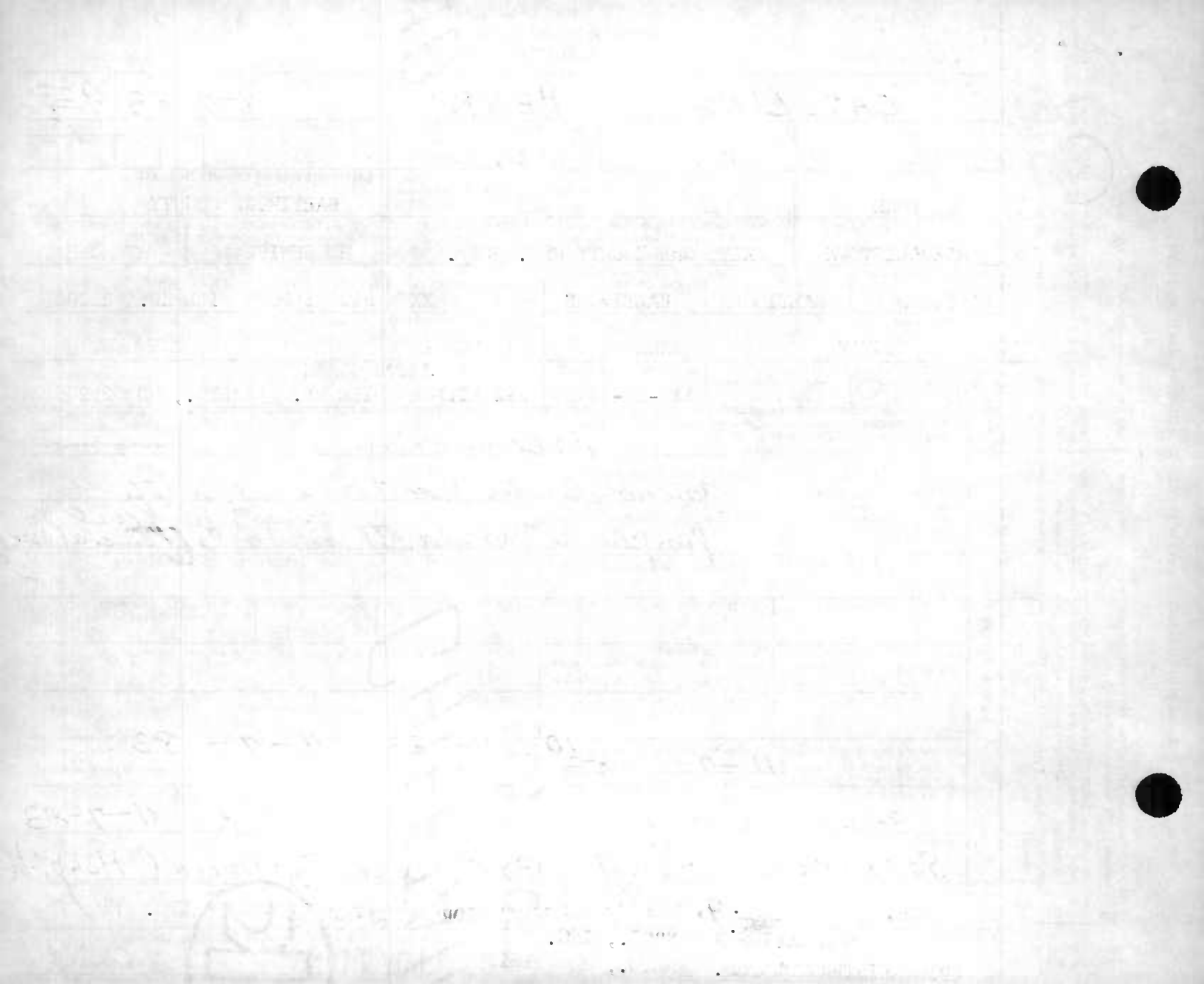
|  |  |                                  |  |   |  |   |  |
|--|--|----------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>   |  | 23b. DATE<br><b>NOV. 9, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MOSES MONTEFIORE WOODMOOR HEBREW</b> |  | 23d. LOCATION<br>CITY STATE<br><b>BALTO. MD</b>     |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b> |  |                                  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 10 1983</b>                           |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b> |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR OFFICE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |         |  |  |   |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
|---|---------|--|--|---|--|-----------------------------------|--|--|--|--------------------------|--|----------|--|------|--|-----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |         | FIRST  |  | MIDDLE  |  | LAST                              |  | 2a. DATE KNOWN OF DEATH                      |  | MONTH                    |  | DAY      |  | YEAR |  | 2b. HOUR  |  |
| Thomas  |         | W.   |  | Henson  |  |                                   |  | 11-26  |  | 19                       |  | 83       |  |      |  | M         |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS)   |  | IF UNDER 1 YR.                    |  | IF UNDER 24 HRS.                             |  | 2c. DATE PRONOUNCED DEAD |  | MONTH    |  | DAY  |  | YEAR      |  |
| M   | B       | 2 8 50   |  | 33  |  |                                   |  |  |  | 11-26                    |  | 19       |  | 83   |  | 4:00 a.m. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED  |  | NEVER MARRIED                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH         |  |                          |  |          |  |      |  |           |  |
| Md.   |         | USA  |  | WIDOWED   |  | DIVORCED                          |  | Baltimore County,                            |  |                          |  |          |  |      |  | MD.       |  |
| 10. CITY OR TOWN OF DEATH   |         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                 |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |  |  |                          |  |          |  |      |  |           |  |
| White Marsh   |         | I-95 north of White Marsh Blvd.  |  | Mechanic  |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| 13a. STATE  |         | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS               |  |  |  |                          |  |          |  |      |  |           |  |
| Md.   |         | Harford  |  | Aberdeen  |  | YES                               |  | 1409 Willshire Drive                         |  |                          |  |          |  |      |  | 21001     |  |
| 14. FATHER'S NAME   |         | 15. MOTHER'S MAIDEN NAME   |  |   |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| Harry   |         | R.   |  | Henson  |  | Florence                          |  | Headen                                       |  |                          |  |          |  |      |  |           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |         | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS                           |  |  |  |                          |  |          |  |      |  |           |  |
| Yes   |         | 1970-1972  |  | 217-50-5544   |  | Harry Henson                      |  | same as above                                |  |                          |  |          |  |      |  |           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         | PART 1 DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)   |  | Multiple Injuries                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |                          |  |          |  |      |  |           |  |
| 8120  |         |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |         |  |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF    |  |  |  |                          |  |          |  |      |  |           |  |
|   |         |  |  | (c)   |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |         |  |  |   |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| 19a. DATE OF OPERATION  |         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?  |  | YES                               |  | XX   |  | NO                       |  |          |  |      |  |           |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| 3:45 PM   |         | 11-26-1983   |  | driver in auto/auto impact  |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION   |  | CITY OR TOWN                      |  | COUNTY                                       |  | STATE                    |  |          |  |      |  |           |  |
|   |         | road   |  | I-95 north of White Marsh Blvd., Balto. Co.,                                  |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: |         | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 22b. TITLE (SPECIFY)  |  | M.D. Assistant                    |  | MEDICAL EXAMINER                             |  | DATE SIGNED              |  | 11-27-83 |  |      |  |           |  |
| ACTUAL SIGNATURE  |         | Dennis F. Smyth, M.D.  |  | ADDRESS   |  | 111 Penn Street                   |  |  |  |                          |  |          |  |      |  |           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |         | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION                     |  | CITY OR TOWN                                 |  | COUNTY                   |  | STATE    |  |      |  |           |  |
| Burial  |         | 12/1/83  |  | Mt. Zion United Meth.   |  | Joppa                             |  | Harford                                      |  | Md.                      |  |          |  |      |  |           |  |
| 24. FUNERAL DIRECTOR  |         | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |
| Arnold Beard 353 Fountain St. Havre de Grace Md.  |         | DEC 1 1983   |  | John J. Connel  |  |                                   |  |  |  |                          |  |          |  |      |  |           |  |



RECEIVED  
JAN 19 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Louise HILLEBRAND</b>                      |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 8, 1983</b> |   |  | 2b. HOUR<br><b>11:30am</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 28 94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br>YRS.         |  |
| 7a. BIRTHPLACE<br>(COUNTRY)<br><b>Maryland</b>                                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                                     |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Retired</b>              |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Housework</b>     |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>54 Mobile Lodge Drive 21222</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Sauer</b>                       |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST               |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>213-74-1184</b>   |   | 17. INFORMANT ADDRESS<br><b>Louis G. Hillebrand 54 Mobile Lodge Dr. 2122</b>  |  |   |  |   |  |

|   |  |   |  |
|---|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Sepsis</b><br><b>4349</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Respiratory Failure Secondary Brain Stem Infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |
|---|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 5, 1983</b> to <b>November 8, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 8, 1983</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Albert Lee M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-8-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert Lee, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>  |  |   |  |

|   |  |                              |  |  |  |  |  |
|---|--|------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  | 23b. DATE<br><b>11-10-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Eastwood, Balto. Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b> |  |                              |  | 25a. DATE RECD. BY REGISTRAR<br><b>NOV 9 1983</b>              |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lewis</b>                             |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be retained by the funeral director for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |  |   |  |  |
|---|--|---|---|--|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>KATHRYN DOLORES HOCK</b>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>NOV. 20, 1983</b> |  |  | 2b. HOUR <b>10<sup>15</sup> A M</b>  |   |  |  |
| 3. SEX <b>Female</b>  |  | 4. RACE <b>White</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 8, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>                                      |   | 6. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY MD.</b>               |   |  |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph Hospital</b> |   |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY                          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b> |  |   | 13c. CITY OR TOWN <b>Baltimore</b>                    |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>1717 Lydonlea Way 21239</b> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Alva L. Pettit</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Helen O. Wolf</b>  |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   | 16b. SOCIAL SECURITY NO. <b>215-05-1174</b>           |  | 17. INFORMANT ADDRESS <b>Charles M. Hock Same</b>  |  |   |  |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

**1749**

IMMEDIATE CAUSE (a) **Myocardial infarction of the heart**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

**3-4**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>              |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov 20</b> , 19 <b>83</b> , to <b>Nov 20</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov 20</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input checked="" type="checkbox"/> view the body after death. |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>Arthur A. Serpick</b>   |  | DEGREE <b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>11/20/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur A. Serpick</b>  |  |   |  | 22e. ADDRESS <b>St. Joseph Hospital</b>  |  |   |  |

|  |  |                                |  |   |  |   |  |
|--|--|--------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>                          |  | 23b. DATE <b>Nov. 23, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Pk.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Parkville, Balto. Co., Md.</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212</b> |  |                                |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 28 1983</b>                |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>                        |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Mary <del>Anna</del> Anna HOERR  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 10, 1983               |   |  | 2b. HOUR<br>6:35am   |  |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 24 13   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>70 YRS  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                         |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOS) OF WORKING LIFE<br>Retired           |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Housework   |  |  |
| 13a. STATE<br>Maryland  |  |   | 13b. COUNTY<br>Baltimore   |   | 13c. CITY OR TOWN<br>Middle River  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br>30 Blister Street 21220 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Harry Hugel   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Regina L. Auld        |   |  | 16. SOCIAL SECURITY NO.<br>218-01-2737   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |   | 16b. SOCIAL SECURITY NO.<br>218-01-2737                                |   |  | 17. INFORMANT ADDRESS<br>Regina L. Auld 30 Blister Street 21220                      |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4275 Obstructive Pulmonary Disease, Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 4, 1983 to November 10, 1983 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on November 10, 1983 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) view the body after death.   |  |   |  |   |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Larry Roe, M.D.   |  |   |  |   | DEGREE<br>MD   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11/10/83                   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |   |  |   | 22e. ADDRESS<br>9000 Franklin Square Drive 21237                               |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  |   | 23b. DATE<br>11-11-83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Westview Mem. Park                       |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Westview, Balto. Co., Md.  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Charles S. Zeiler & Son Inc.  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1983                                   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Lohr   |  |  |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ATTACH WITH FORM NO. 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

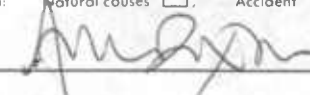

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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28371

REG. NO.

|   |                         |   |   |   |  |   |  |   |   |
|---|-------------------------|---|---|---|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>RICHARD CHARLES HOFFMAN</b>  |                         |   |   | 2a. DATE OF DEATH<br>KNOWN <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <b>11 3 1983</b>  |  |   |  | 2b. HOUR<br><b>AM</b>   |   |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>Nov.</b> DAY <b>12</b> YEAR <b>1961</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY <b>21</b> YRS. | IF UNDER 1 YR.<br>MONTHS <b>21</b> DAYS   | IF UNDER 24 HRS.<br>HOURS <b>21</b> MIN. | 2c. DATE PRONOUNCED DEAD<br><b>11 3 1983</b>  |  | 2d. HOUR<br><b>3:51</b><br><b>AM</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.   |  |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Woodlawn</b>  |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>(auto) Security Mall Parking Lot</b> |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Sales Representative</b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Photography</b>                             |   |
| 13a. STATE<br><b>Maryland</b>   |                         | 13b. COUNTY<br><b>Baltimore</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |  | 13e. STREET ADDRESS<br><b>1505 Woodcliff Avenue 21228</b>                           |   |
| 14. FATHER'S NAME<br>FIRST <b>Charles</b> MIDDLE <b>Richard</b> LAST <b>Hoffman</b>   |                         |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Mary</b> MIDDLE <b>Margaret</b> LAST <b>Boskind</b>  |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>Yes</b>   |                         | 16b. SOCIAL SECURITY NO.<br><b>1982 220-88-5726</b>   |   | 17. INFORMANT ADDRESS<br><b>Charles R. Hoffman 1505 Woodcliff Ave.</b>  |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gunshot wound of chest (rifle)</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost:<br>b)<br>c)<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). |                         |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |
| 19a. DATE OF OPERATION  |                         |   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>? P.M. 11-3- 1983</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Self-inflicted.</b>   |  |   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>(auto)</b>  |   | 21f. LOCATION<br>STREET <b>Security Mall Parking Lot, Woodlawn, Balto., Md</b><br>CITY OR TOWN <b>Baltimore</b> COUNTY <b>Baltimore</b> STATE <b>Md.</b>    |  |   |  |   |   |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .<br>Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion   |                         |   |   |   |  |   |  |   | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER |
| ACTUAL SIGNATURE<br>   |                         | DATE SIGNED<br><b>11-3-83</b>   |   |   |  | DATE SIGNED<br><b>11-3-83</b>   |  |   |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>   |                         | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>   |   |   |  |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>  |                         | 23b. DATE<br><b>Nov. 4, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Westview Crematory</b>   |  |   |  | 23d. LOCATION<br>CITY OR TOWN <b>Catonsville</b> COUNTY <b>Md.</b>                  |   |
| 24. FUNERAL DIRECTOR<br><b>Larry M. &amp; Russell C. Witzke Funeral Homes P.A.</b>  |                         |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 4 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br> |  |   |   |
| 1630 Edmondson Avenue, Catonsville, Md. 21228   |                         |   |   |   |  |   |  |   |   |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |   |  |  |  |                            |                                |
|--|---|---|--|--|--|----------------------------|--------------------------------|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ANNETTE E. HOLLAND</b> |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-8-83</b>                                |  |  | 2b. HOUR<br><b>9 38</b> M. |                                |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>09-04-85</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>98</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS                   |                            | IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>FLORIDA</b>      | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTO. COUNTY</b> MD.                     |  |  |                            |                                |
| 10. CITY OR TOWN OF DEATH<br><b>BALTO.</b>                       | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>MANOR CARE - RUXTON</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b> |                            |                                |

|   |                              |  |   |  |  |
|---|------------------------------|--|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                              |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>1321 DARTMOUTH AVE. 21234</b> |  |
| 13a. STATE<br><b>MD.</b>  | 13b. COUNTY<br><b>BALTO.</b> | 13c. CITY OR TOWN<br><b>BALTO.</b>         |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN E. HOSSBACH</b>                       |                              |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ANNA SCHIRLE</b>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No.</b>      |                              | 16b. SOCIAL SECURITY NO.<br><b>UNKNOWN</b> | 17. INFORMANT ADDRESS<br><b>Mr. Herbert Holland - 1321 Dartmouth Ave. 21234</b>                 |  |  |

|  |  |   |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:  |  |   |

|  |  |  |  |   |   |
|--|--|--|--|---|---|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-3-1983</b> , to <b>11-3-1983</b> , that (I) (we) last saw the deceased alive on <b>11-3-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |
| 22b. SIGNATURE<br><b>Clear</b>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/9/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |   |

|   |                              |  |   |
|---|------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> | 23b. DATE<br><b>11-10-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |
| 23e. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1983</b>            |                              | 23f. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>        |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28 P. 128-8-11

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MARTIN H HOLTMAN SR</b>                                  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 83</b> |   |  | 2b. HOUR<br><b>5.0 P.M.</b>   |  |
| 3. SEX<br><b>M</b>  |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 30 1901</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b>                                    |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>COUNTY - BALTO</b> MD.               |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>ST. JOSEPH HOSP.</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Rtd.</b> |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>R.R.</b>  |  |  |  |   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>MD</b> |  |  |  |   |  |   |  |
| 13c. CITY OR TOWN<br><b>BALTIMORE</b>   |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 13e. STREET ADDRESS<br><b>942 Woodlyn Rd</b>  |  |  |  | 13f. STREET ADDRESS<br><b>21221</b>   |  |   |  |

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>UNK</b>                               |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>UNK</b> |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>UNK</b> |  | 16b. SOCIAL SECURITY NO.<br><b>705-052345</b> |   | 17. INFORMANT<br>ADDRESS<br><b>Daughter - DANNA, CATHERINE 1935 WAREHAM</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiac Pulmonary arrest**  
1541  
DUE TO, OR AS A CONSEQUENCE OF  
(b) **Recurrent Carcinoma Rectum**  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>9.14.83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bowel obstruction</b> |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>            |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)       |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |

22a. I certify that (I) (this hospital) attended the deceased from **9.9**, 19 **83**, to **11.13**, 19 **83**, that (I) (we) last  
saw the deceased alive on **11.13**, 19 **83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

|  |  |  |  |                                     |  |
|--|--|--|--|-------------------------------------|--|
| 22b. SIGNATURE<br><b>Suma Law</b>                              |  | DEGREE   |  | 22c. DATE SIGNED<br><b>11-13-83</b> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MIRZA M. AHMAD</b> |  | 22e. ADDRESS<br><b>ST. JOSEPH HOSP. 7620 YORK ROAD TOWSON MD</b> |  |                                     |  |

|   |  |                              |  |   |  |  |  |
|---|--|------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b> |  | 23b. DATE<br><b>11/17/83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>          |  |                              |  | ADDRESS<br><b>300 MALE</b>                                |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 16 1983</b>             |  |
|   |  |                              |  | 26. REGISTRAR'S SIGNATURE<br><b>John J. Connelly</b>      |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the state after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION



WVK

WVK

WVK

Handwritten text, possibly "Handwritten" and "Handwritten".



1-1-182 CHRE New

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE REGISTRAR. RETAIN PAGE 4. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 28874

1- FOR  
STATE  
REGISTRAR

|  |                      |  |  |  |   |
|--|----------------------|--|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>FRANCES May HOMER</b>   |                      |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>11</b> DAY <b>11</b> YEAR <b>1983</b> 2b. HOUR <b>6<sup>45</sup> PM</b> |  |   |
| 3. SEX <b>Female</b>   | 4. RACE <b>White</b> | 5. DATE OF BIRTH<br>MONTH <b>Dec.</b> DAY <b>3</b> YEAR <b>1920</b>  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS.   | IF UNDER 1 YR. MONTHS DAYS HOURS MIN.  | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH <b>Baltimore</b>   |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Greater Balto. Med. Center</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>   |   |
| 13a. STATE <b>Maryland</b>   |                      | 13b. COUNTY <b>Balto.</b>  |  | 13c. CITY OR TOWN <b>Riderwood</b>   |   |
| 14. FATHER'S NAME<br>FIRST <b>Harry</b> MIDDLE <b>Louis</b> LAST <b>Homer</b>  |                      | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>May</b> MIDDLE <b>-</b> LAST <b>Clifton</b>   |  | 16. SOCIAL SECURITY NO. <b>189-20-6833</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>  |                      | 16b. SOCIAL SECURITY NO. <b>189-20-6833</b>  |  | 17. INFORMANT ADDRESS <b>Riderwood, Md.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic obstructive pulmonary disease</b><br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                      |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |                      |  |  |  |   |
| 19a. DATE OF OPERATION   |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                      |  |  |  |   |
| ACTUAL SIGNATURE <b>R. Breiteneker</b>   |                      | M.D. <b>Dep.</b>   |  | MEDICAL EXAMINER   |   |
| EXAMINER'S NAME (TYPE OR PRINT) <b>R. BREITENECKER</b>   |                      | ADDRESS <b>GBMC</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |                      | 23b. DATE <b>Nov. 14, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>   |   |
| 24. FUNERAL DIRECTOR NAME <b>Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd</b>   |                      | 25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 4).

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| DECEASED NAME FIRST MIDDLE LAST<br><b>HOPKINS, BERNARD J</b>  |  |  |  | 11/06/83 8:40P 8:40P  |  |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>7 - 31 - 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br><b>77</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>New Hampshire</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD.</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SAINT JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>President</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Security Service</b>  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Towson</b>  |  | 13e. STREET ADDRESS<br><b>48 Theo Lane - 21204</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph Hopkins</b>  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Anna Hoey</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>024-07-0365</b>   |  | 17. INFORMANT ADDRESS<br><b>Helen F. Hopkins - Same as #13e</b>   |  |   |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma</b><br><b>1991</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/16</b> , 19 <b>87</b> , to <b>11/6</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/16</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE <b>Phil Buercher</b>   |  |  |  | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>           |  | 22c. DATE SIGNED<br><b>11/6/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Phil Buercher</b>   |  |  |  | 22e. ADDRESS  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-10-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Timonium Balto., Md.</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |  |  |  | ADDRESS<br><b>1050 York Rd. Towson, Md. 21204</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 8 1983</b>  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

BP



**Abstract**

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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1050 York Rd.

5050 York Rd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filled with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

28876

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>M. FAWCETT</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-29-83</b> |   |  | 2b. HOUR<br>7:25 PM   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 7, 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD                                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore Co. General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Executive</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>BGE</b>  |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Carroll</b>  |  | 13c. CITY OR TOWN<br><b>Bykesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>1200 3rd Ave, C-0-53</b>   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Milton O. Hopkins</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Bertha Fawcett</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) <b>—</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>212-05-6379</b>  |  | 17. INFORMANT<br><b>Wilhelmina P. Hopkins</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4349</b><br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Cerebrovascular infarct</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Hypertension</b> |  | 19. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hypertension</b>  |  |  |  |   |  |   |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |  | 21e. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  | 21g. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21h. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  | 21i. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-18-</b> 19 <b>83</b> to <b>11-29-</b> 19 <b>83</b> that (I) (we) last saw the deceased alive on <b>11-29-</b> 19 <b>83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Soonchul Hong</b>  |  | 22c. DEGREE  |  | 22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>             |  | 22e. DATE SIGNED<br><b>11-29-83</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>SOON CHUL HONG</b>  |  | 22e. ADDRESS<br><b>Baltimore county General Hospital</b>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Dec 2, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Margarets</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Annapolis A.A. MD</b>  |  | 23e. DATE REC'D. BY REGISTRAR<br><b>DEC-2-1983</b>   |  | 23f. REGISTRAR'S SIGNATURE<br><b>John J. Carroll</b>  |  | 23g. REGISTRAR'S SIGNATURE  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Taylor Funeral Chapel-Annapolis, MD</b>  |  | 24b. ADDRESS<br><b>Annapolis, MD</b>   |  | 24c. DATE REC'D. BY REGISTRAR<br><b>DEC-2-1983</b>  |  | 24d. REGISTRAR'S SIGNATURE<br><b>John J. Carroll</b>  |  |  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lois L. Howard</b> |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 28 83</b> |   |  | 2b. HOUR<br>M<br><b>M</b>   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3 1 1927</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>56</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>                 |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                             |  |
| 10. CITY OR TOWN OF DEATH<br><b>Dundalk</b>                                       |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>303 German Hill Road</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cook</b>                 |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Del Capri</b>                             |  |  |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Dundalk</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET ADDRESS<br><b>303 German Hill Road 21222</b>                          |  |  |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Lee A. Gano</b>                      |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sadie M. Anderson</b>  |  | ADDRESS<br><b>303 German Hill Rd. Balto., MD. 21222</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b> |  | 16b. SOCIAL SECURITY NO.<br><b>220-18-8751</b>   |  | 17. INFORMANT<br><b>Albert C. Howard</b>  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardio-respiratory arrest**1629  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) **Brain metastasis**(c) **Adenocarcinoma of the lung**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

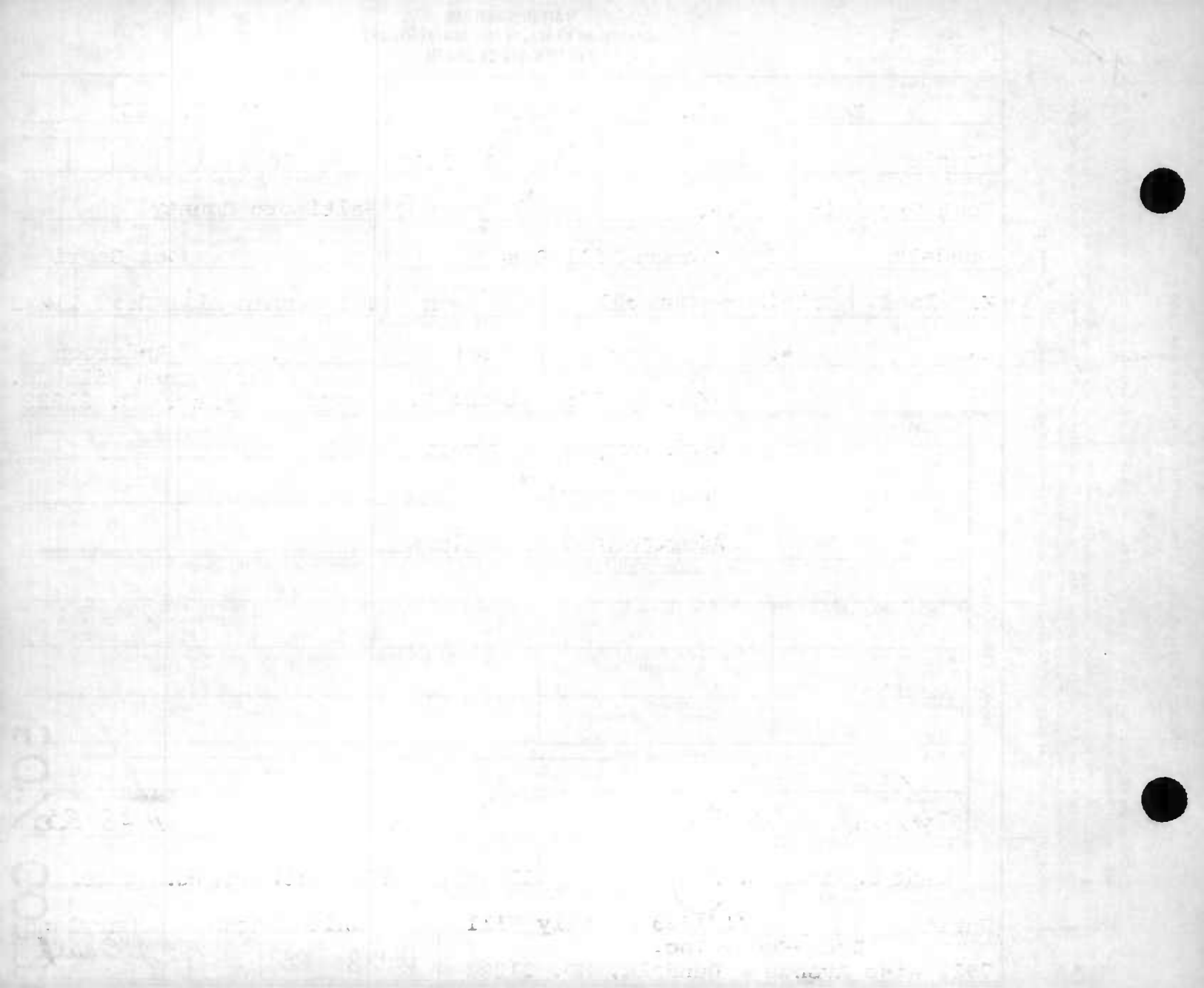
|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost<br>saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Louis L. Munoz</i>   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-28-83</b>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Louis L. Munoz, M.D.</b>  |  | 22e. ADDRESS<br><b>600 North Wolfe Baltimore, Md. 21205</b>  |  |  |  |   |  |

|   |  |                               |  |   |  |   |  |
|---|--|-------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> |  | 23b. DATE<br><b>12/1/1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holly Hill</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>White Marsh Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Duda-Ruck, Inc.</b>        |  |                               |  | ADDRESS<br><b>7922 Wise Avenue Dundalk, MD. 21222</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1983</b>                        |  |
|   |  |                               |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Conish</i>                       |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |   |  |   |  |
|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>CLARENCE Jerome HUFF</b>  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11-19-83</b>  |   | 2b. HOUR<br><b>545</b> M   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>Caucasian</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Sept. 30 1887</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>96</b> YRS.                                |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>              |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Baltimore County General Hospital</b> |  | 12a. USUAL OCCUPATION<br>TYPE OF WORK FOR MOST OF WORKING LIFE<br><b>Head Custodian</b>         | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Milford Mill H.S.</b>                    |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Huff</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Emma Jane Frock</b>  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>218-18-7791</b>   |   |  |
| 16c. FORMER ADDRESS<br><b>8012 Douglas Ave. Baltimore, Maryland 21207</b>  |   | 16d. ADDRESS<br><b>Huff</b>  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b><br><b>4292</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ARTERIO-SCLEROTIC CARDIOVASCULAR DIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>URINARY TRACT INFECTION</b>   |   |  |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>        |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-17-1983</b> to <b>11-19-1983</b> , that (I) (we) lost saw the deceased alive <b>11-19-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) see the body after death.  |   |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE<br><b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11-19-83</b>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>VUNDARA V. REDDY</b>   |   | 22e. ADDRESS<br><b>BALTO. COUNTY GEN HOSP<br/>Randallstown MD 21133</b>  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11-23-83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Woodlawn Baltimore Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, Maryland 21133</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1983</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                 |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the top center, possibly a date or reference number.

Handwritten text in the upper middle section, possibly a title or header.

Handwritten text on the left side, possibly a name or address.

Handwritten text on the right side, possibly a name or address.

Handwritten text across the middle section, possibly a paragraph or list.

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Gary Douglas HUFFER  |  |  |  | 2b. HOUR<br>6:34 P.M.   |  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>Jan. 18, 1938  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br>45   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>West Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Franklin Square Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Data Processing State Gov't  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Essex  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Riner Huffer  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Mary Pearrell  |  | 13e. STREET ADDRESS<br>626 N. Woodward Dr. 21221  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>236.50.1259  |  | 17. INFORMANT ADDRESS<br>Ruth M. Huffer (Wife) (Same as 13e)  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory arrest</u><br>1629<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinoma of the lung</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Oct. 26</u> , 19 <u>83</u> , to <u>Nov. 2</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Nov. 2</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. |  |  |  |   |  |   |  |
| 22b. SIGNATURE <u>STEVEN SALZBERG</u>  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br>11/2/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>STEVEN SALZBERG   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>11/3/1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Crematory   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Baltimore Maryland   |  |
| 24. FUNERAL DIRECTOR<br>Walter Brooks Bradley Inc., Balto Md.  |  |  |  | 25a. REC'D BY REGISTRAR<br>NOV 4 1983   |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>  |  |

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20% COLLECTION

CHIEF TAX

STATION CHIEF

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |  |  |   |   |
|---|---|---|---|--|--|---|---|
| 1. FOR<br>STATE<br>REGISTRAR  |   | 2a. DATE OF DEATH   |   | MONTH  | DAY  | YEAR  | 2b. HOUR  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | FIRST   | MIDDLE  | LAST   |  | 2b. HOUR  |   |
| Dorothy   |   | O.  | HUNT  |  | November 24, 1983                          |   | 6:45P M   |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     | 7. UNDER 1 YEAR  |  | 8. UNDER 24 HRS   |   |
| FEMALE  | CAUCASIAN   | MONTH DAY YEAR<br>07 27 18  | 65 YRS.   | MONTHS   | DAYS                                       | HOURS   | MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY?  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |   |   |
| WEST VIRGINIA   | USA   |   | Baltimore County MD.  |  |  |   |   |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)    |  | 12b. KIND OF BUSINESS OR INDUSTRY          |   |   |
| ROSSVILLE   | FRANKLIN SQUARE HOSPITAL  |   | HOUSEWIFE   |  | -----                                      |   |   |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |   | 13b. CITY OR TOWN   | 13c. INSIDE CITY LIMITS?  | 13d. STREET ADDRESS / ZIP CODE   |  |   |   |
| 13a. STATE  |   | BALTIMORE   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 2919 FLEETWOOD AVE. 21211  |  |   |   |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   | ADDRESS  |  |   |   |
| FIRST MIDDLE LAST<br>MILTON ROSS  |   | FIRST MIDDLE LAST<br>-----  |   | -----  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |  |   |   |
| NO  |   | 217057801   |   | JUNE DONOVAN 817 FALCONER RD.  |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:  |   |   |   |  |  |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Cardio Respiratory Arrest   |   |   |   |  |  |   |   |
| 1991 DUE TO, OR AS A CONSEQUENCE OF   |   |   |   |  |  |   |   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Widespread terminal metastatic disease   |   |   |   |  |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |   |   |   |  |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |  |   |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |
|   |   |   |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |   |
| 22a. I certify that (a) (this hospital) attended the deceased from November 22, 1983, to November 24, 1983, that (we) last saw the deceased alive on November 24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. |   |   |   |  |  |   |   |
| 22b. SIGNATURE  |   | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED  |   |
| Darius G. Russin  |   |   |   |  |  | 11/24/83  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   |  |  |   |   |
| DARIUS G RUSSIN   |   | 9000 Franklin Square Dr., 21237   |   |  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |   | 23b. DATE   | 23c. NAME OF CEMETERY OR CREMATORY                                  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |   |   |
| BURIAL  |   | 11/28/83  | OAKLAWN   |  | BALTO. BALTO. MD.                          |   |   |
| 24. FUNERAL DIRECTOR  |   | 25a. DATE REC'D. BY REGISTRAR   |   | 25b. REGISTRAR'S SIGNATURE   |  |   |   |
| J. J. Connel  |   | NOV 28 1983   |   | John J. Connel   |  |   |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Form with multiple sections and fields, including a header area with "UNITED STATES" and "DEPARTMENT OF JUSTICE". The form contains various checkboxes, text boxes, and a large section for "FEDERAL BUREAU OF INVESTIGATION". The bottom section includes a date field and a signature line.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |  |   |  |  |   |  |
|---|--|--|---|--|---|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |   |  | REG. NO. 2 8 8 8 1  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>CARROLL S HUTTON</b>  |  |  |   |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>05</b> YEAR <b>83</b>  |  |  | 2b. HOUR <b>1:15PM</b>  |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>   |   | 5. DATE OF BIRTH MONTH <b>8</b> DAY <b>6</b> YEAR <b>1917</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE COUNTY</b> MD.                             |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GBMC 6701 N CHARLES ST</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Printer</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>   |  |
| 13a. STATE <b>Md.</b>   |  | 13b. COUNTY <b>Balto</b>   |   | 13c. CITY OR TOWN <b>Lutherville</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE <b>221 Charmuth Rd. - 21093</b>  |  |
| 14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Hutton</b> LAST <b>Hutton</b>   |  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Lula</b> MIDDLE <b>Ewing</b> LAST <b>Ewing</b>  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  |  |   |  | 16b. SOCIAL SECURITY NO. <b>WW11 219 01 1962</b>  |  | 17. INFORMANT ADDRESS <b>Mrs Shirley H. Hutton Same</b>              |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONGESTIVE CARDIOMYOPATHY</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yr.</b> |  |  |   |  |   |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>REFRACTORY VENTRICULAR ARRHYTHMIA</b>   |  |  |   |  |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11-03 83</b> P.M. <b>19</b> |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)         |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-03 83</b> to <b>11-05 83</b> , that (I) (we) last saw the deceased alive on <b>11-05 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death)   |  |  |   |  |   |  |  |   |  |
| 22b. SIGNATURE <b>N. Rosenblum</b>  |  |  |   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED <b>5 Nov 83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. N. ROSENBLUM</b>   |  |  |   |  | 22e. ADDRESS <b>GBMC 6701 N. CHARLES ST, TOWSON MD</b>  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  |  | 23b. DATE <b>11/8/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Mem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Cockeysville Balto Md</b> |   |  |
| 24. FUNERAL DIRECTOR NAME <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd.</b>   |  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR <b>NOV 10 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |   |   |                     |
|---|---|---|---|---|---------------------|
| 1. FOR STATE REGISTRAR  |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |                     |
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |   | 2a. DATE OF DEATH   |   | 2b. HOUR  |                     |
| EMIL JOSEPH HYLLA   |   | NOV. 8, 1983  |   | 12 <sup>30</sup> P.M.   |                     |
| 3. SEX  | 4. RACE   | 5. DATE OF BIRTH  | 6. AGE  | 7. BALTIMORE CITY OR COUNTY OF DEATH  |                     |
| M   | W   | 4/6/17  | 66 YRS.   | BALTO. COUNTY MD.   |                     |
| 7a. BIRTHPLACE  | 7b. CITIZEN OF WHAT COUNTRY?                            | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |                     |
| MD.   | USA   |   | BALTO. COUNTY MD.   |   |                     |
| 10. CITY OR TOWN OF DEATH   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | 12a. USUAL OCCUPATION   | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |                     |
| ROSSVILLE   | FRANKLIN SQ   | (TYPE OF WORK FOR MOST OF WORKING LIFE)   | BREWERY   |   |                     |
| 13a. STATE  |   | 13b. COUNTY   | 13c. CITY OR TOWN   | 13d. INSIDE CITY LIMITS?  | 13e. STREET ADDRESS |
| MD.   | BALTO   | MIDDLE RIVER  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 4005 BAY DR. 21220  |                     |
| 14. FATHER'S NAME   |   | 15. MOTHER'S MAIDEN NAME  |   |   |                     |
| EMIL HYLLA  |   | UNK   |   |   |                     |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  |   | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |                     |
| YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)   |   | 213052193   |   | FRIEDA HYLLA  |                     |
| 18. CAUSE OF DEATH  |   | 18b. SOCIAL SECURITY NO.  |   | 17. INFORMANT   |                     |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden Cardiac Death, Ventricular Fibrillation</u>   |   | 213052193   |   | FRIEDA HYLLA  |                     |
| 4292  |   | DUE TO, OR AS A CONSEQUENCE OF  |   | A BOVE  |                     |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |   | (b) <u>Atherosclerotic Cardiovascular Disease</u>   |   | Life  |                     |
|   |   | (c) <u>Disease</u>  |   |   |                     |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |   |   |   |   |                     |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?   |                     |
|   |   |   |   | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |                     |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |                     |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |                     |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>83</u> , to <u>11-8</u> , 19 <u>83</u> , that (1) (we) last saw the deceased alive on <u>10-16</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (and not) view the body after death. |   | 22b. SIGNATURE<br><u>JB Little</u>  |   | 22c. DATE SIGNED  |                     |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |   | 22e. ADDRESS  |   | 22f. DATE SIGNED  |                     |
| JB LITTLETON  |   | 1012 Old Northpark Rd   |   |   |                     |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |   | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY  |                     |
| BURIAL  |   | 11/11/83  |   | LODGE PARK  |                     |
| 23d. LOCATION   |   | 23e. DATE REC'D. BY REGISTRAR   |   | 23f. REGISTRAR'S SIGNATURE  |                     |
| BALTO. MD.  |   | NOV 14 1983   |   | John J. Connelly  |                     |
| 24. FUNERAL DIRECTOR  |   | 24a. NAME   |   | 24b. ADDRESS  |                     |
| J-G. CONNELLY   |   | 300 MACE  |   |   |                     |





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

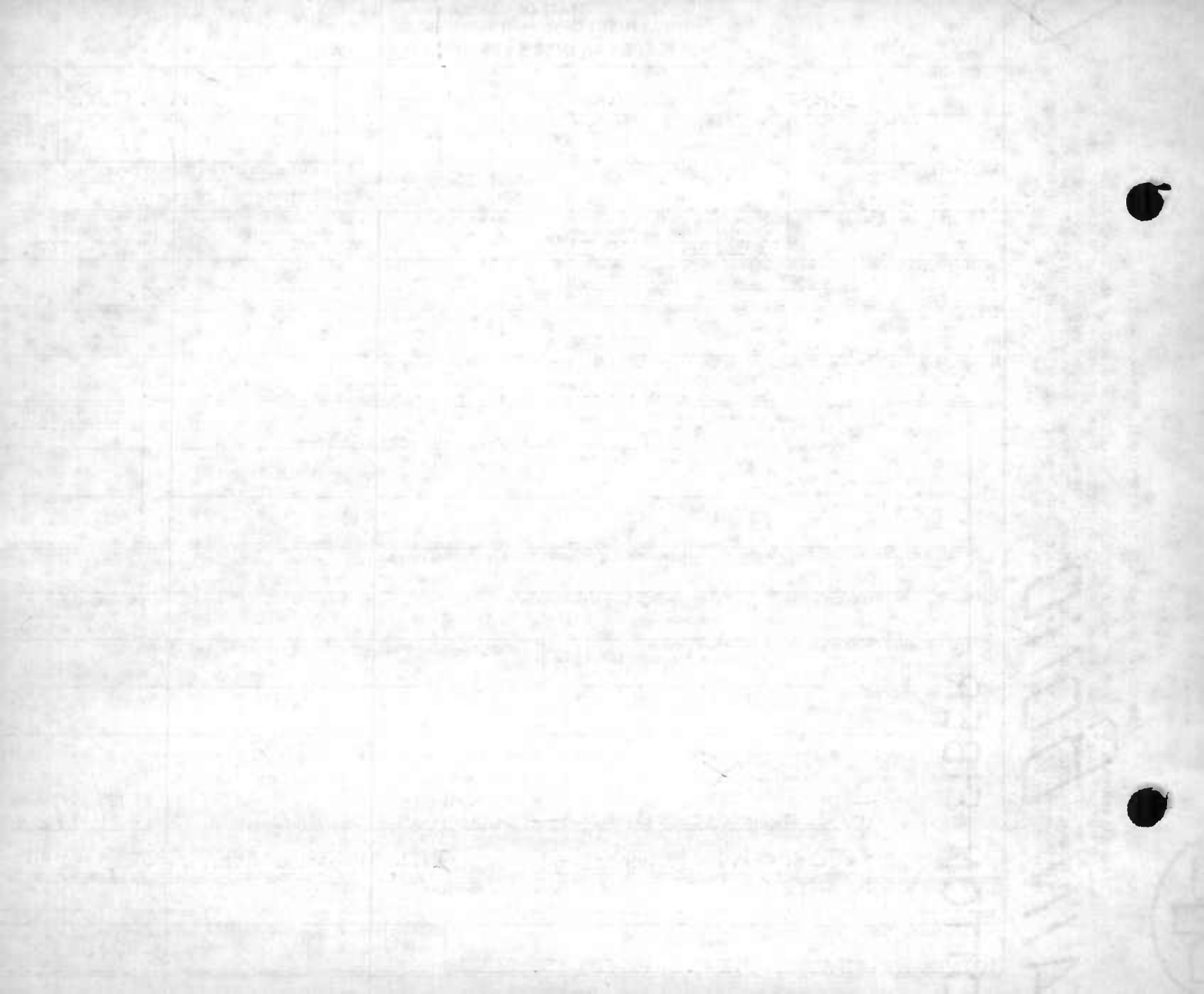
BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

28883  
REG. NO.

|   |                         |   |  |   |   |
|---|-------------------------|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>GEORGE WILSON JACKALL</b>  |                         | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 11 18 1983   |  | 2b. HOUR<br>0100 M  |   |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>10/7/1910</b>  | 6. AGE (IN YEARS)<br>LAST BIRTHDAY<br><b>73</b> YRS. | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN.  | 7c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>11 18 1983</b> |
| 7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>  |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>DUNDALK</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>3101 ARDEE WAY 21222</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |   |
| 13a. STATE<br><b>MARYLAND</b>   |                         | 13b. CITY OR TOWN<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>DUNDALK</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN JACKALL</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NORA SEESE</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>EXPEDITOR</b>   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>213.30.1895</b>  |  | 17. INFORMANT<br><b>MARY M. JACKALL</b>   |   |
|   |                         |   |  | ADDRESS<br><b>SAME AS 13c.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute intracerebral hemorrhage</b><br><b>4310</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF   |                         |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                    |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                         |   |  |   |   |
| 19a. DATE OF OPERATION  |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |   |  |   |   |
| ACTUAL SIGNATURE <b>J. Crossan O'Donovan</b>  |                         | TITLE (SPECIFY)<br><b>Deputy</b>  |  | DATE SIGNED <b>11/18/83</b>   |   |
| EXAMINER'S NAME (TYPE OR PRINT) <b>J. CROSSAN O'DONOVAN</b>   |                         | ADDRESS <b>2112 DUNDALK AVE, BALT., MD 21222</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |                         | 23b. DATE<br><b>11/21/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>WALTER BROOKS BRADLEY, INC.</b>  |                         | ADDRESS<br><b>DUNDALK, MD. 21222</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1983</b>   |   |
|   |                         |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conish</b>   |   |
|   |                         |   |  | 26. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTIMORE MARYLAND</b>   |   |



— 2 8 8 8 4

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH  |  | MONTH YEAR   |  | 2b. HOUR                                     |  |
| ELIZABETH H. JACKSON  |  |  |  | 11 20 83   |  | 8:00AM   |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                |  | 7. IF UNDER 1 YEAR                           |  |
| Female  |  | White  |  | July 15 1903   |  | 80   |  | MONTHS DAYS HOURS MIN.                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                           |  |  |  |
| N. H.   |  | U.S.A.   |  |  |  | BALTIMORE COUNTY   |  | MD.  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                              |  |  |  |
| TOWSON  |  | GBMC 6701 N. CHARLES ST  |  | Housewife  |  | Own Home   |  |  |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                       |  | 13e. STREET ADDRESS / ZIP CODE               |  |
| Md.   |  | Balto.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 207 Club Road  |  | 21210  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.                                       |  | 17. INFORMANT                                |  |
| Charles M. Horne  |  | Margaret E. Doherty  |  | No   |  | 220-44-6974  |  | Everett E. Jackson IV                        |  |
|   |  |  |  |  |  |  |  | Same   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  | 18. IMMEDIATE CAUSE (a).   |  | DUE TO, OR AS A CONSEQUENCE OF (b).  |  | DUE TO, OR AS A CONSEQUENCE OF (c).                            |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 1509  |  | PULMONARY CONGESTION   |  | ESOPHAGEAL CANCER  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  | COPD   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |  |  |
|   |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-10 1983, to 11-20 1983, that (I) (we) lost saw the deceased alive on 11-20 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>               |  | 22c. DATE SIGNED   |  |  |  |
| DR. K. BYERLY MD  |  |  |  |  |  | 11/20/83   |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |  |  |  |  |
|   |  | GBMC 6701 N. CHARLES ST, TOWSON MD   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                        |  |  |  |
| Burial  |  | 11-23-83   |  | Parsons  |  | Salisbury Wicomico Md.   |  |  |  |
| 24. FUNERAL DIRECTOR NAME   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE                                     |  |  |  |
| Henry W. Jenkins & Sons Co., Balto., Md.  |  |  |  | NOV 22 1983  |  | John J. Connelley  |  |  |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



11 20 13 3:00AM

JACKSON

ELIZABETH

BALTIMORE COUNTY

CHARLES ST

CHANC 701

TOWSON

607 Club Road

X

Patrol

MA

Dobson

W. McNeal

Horne

C. H. H.

PLANTATION COMMISSION

ES. PRINCEAL C. CER

COPIED

11 20 13

11 13

11 20

CHANC 6701 . CHARLES ST TOWSON MD

DR. J. SYLTY MD

Baltimore, Maryland

Person

11 23 13

Chief

Henry W. Jackson & Sons Co., Baltimore, Md.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

|   |   |   |   |  |  |  |                                   |  |
|---|---|---|---|--|--|--|-----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Pauline E. Jarvis</b>  |   |   | 2a. DATE OF DEATH<br><b>11-16-83</b>  |  |  | 2b. HOUR<br><b>8:50</b> M                        |                                   |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>                       | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>6</b> YEAR <b>18</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |                                   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Tenn.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.                           |  |  |                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Balto. Co. Gen. Hosp.</b>                   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE <b>Ind.</b> COUNTY <b>Balto.</b> CITY OR TOWN <b>Reisterstown</b> |   |   | 13b. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13c. STREET ADDRESS<br><b>21136 17 Westminister Pike</b>                             |  |                                   |  |
| 14. FATHER'S NAME<br>FIRST <b>Benjamin</b> MIDDLE <b>M</b> LAST <b>Latin</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Victoria</b> MIDDLE <b>M</b> LAST <b>Watt</b>              |  |  |  |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>225-24-2256</b>  |   | 17. INFORMANT<br><b>Russell Jarvis</b> ADDRESS <b>17 Westminister Pk Reisterstown, Ind</b> |  |  |                                   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**1 hr**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>1-28</b> , 19 <b>82</b> , to <b>11-16</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) last saw the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Darold K. Beard</b>  |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/17/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DAROLD K. BEARD, MD</b>   |  | 22e. ADDRESS<br><b>11 E Chestnut Hill La Reisterstown, Md 21136</b>    |  |  |  |   |  |

|  |                                   |   |   |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(AS REQUESTED)<br><b>Burial</b> | 23b. DATE<br><b>Nov. 21, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Garrison Forest V.A.</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Owings Mills, Balto, Ind</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>H. F. Schhardt</b>              |                                   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1983</b>               |   |
| ADDRESS<br><b>Owings Mills, Ind</b>                                |                                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. C... ..</b>              |   |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR ROSE M. JENSEN  |  |  |  |  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Rose M. JENSEN</b>   |  |  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>2</b> YEAR <b>83</b> 2b. HOUR <b>6 am</b> MIN.  |  |  |  |
| 3. SEX <b>FEMALE</b>   |  | 4. RACE <b>WHITE</b>   |  | 5. DATE OF BIRTH MONTH <b>3</b> DAY <b>29</b> YEAR <b>95</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Baltimore</b> MD   |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>UNIVERSITY VIEW NURSING HOME</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>JEWELRY</b>   |  |
| 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>ROSEDALE</b>  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS <b>8356 OLD PHILADELPHIA RD</b> 21237  |  |
| 14. FATHER'S NAME FIRST <b>EMIL</b> MIDDLE <b>---</b> LAST <b>KUHL</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST <b>JULIA</b> MIDDLE <b>LOUISE</b> LAST <b>KURTZWEG</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NA</b>  |  | 16b. SOCIAL SECURITY NO. <b>N7A</b>  |  | 17. INFORMANT <b>HAZEL M. SNYDER</b> ADDRESS <b>8356 OLD PHILADELPHIA RD</b> 21237   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stroke with (L) hemiparesis</b> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetes - osteoarthritis - NG feeding</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4360</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes - osteoarthritis - NG feeding</b>   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>10/24/83</b> to <b>11/2/83</b> that (I) <del>also</del> lost saw the deceased alive on <b>10/31/83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> did not view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE <b>[Signature]</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>12/2/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VUONG VU NGUYEN</b>   |  |  |  | 22e. ADDRESS <b>5331 BELAIR RD</b> 21246.  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>   |  | 23b. DATE <b>11/3/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTO BALTO MD</b>  |  |
| 24. FUNERAL DIRECTOR NAME <b>[Signature]</b> ADDRESS <b>1211 Chesapeake Ave</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 3 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |

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FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |   |  |  |  |  |
|--|---|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT) <b>Doris O. Jett</b>  |   |  | 2a. DATE OF DEATH<br>MONTH <b>November</b> DAY <b>21</b> YEAR <b>1983</b>      |  | 2b. HOUR<br>M  |
| 3 SEX<br><b>Female</b>   | 4 RACE<br><b>Black</b>  | 5. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>27</b> YEAR <b>26</b>   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br><b>57</b> YRS.                         | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>   |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore Co.</b> MD.          |  |
| 10 CITY OR TOWN OF DEATH<br><b>Lochearn</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6724 Campfield Road</b> |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE <b>MD</b> 13b COUNTY <b>Baltimore</b> 13c CITY OR TOWN <b>Lochearn</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 13e STREET ADDRESS<br><b>6724 Campfield Rd. 21207</b>                          |  |  |
| 14 FATHER'S NAME<br>FIRST <b>Howard</b> MIDDLE <b></b> LAST <b>Beulah</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Lillian</b> MIDDLE <b></b> LAST <b>Haynes</b>   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>UNKNOWN</b> (IF YES, GIVE WAR OR DATES)   |   | 16b SOCIAL SECURITY NO.<br><b>220-22-4520</b>  | 17 INFORMANT ADDRESS<br><b>Maria Hord 1131 Wedgewood Road</b>                  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Gastric Adenocarcinoma Ten months</b><br><b>1519</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b></b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>  |   |  |  |  |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME STREET FACTORY OFFICE, FARM, ETC.)  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> 19 <b>83</b> , to <b>November</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>November</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Marshall A. Levine</b>  |   | DEGREE <b>MD</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/22/83</b>                                      |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Marshall A. Levine</b>   |   | 22e. ADDRESS<br><b>711 W. 40th St. Baltimore, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SP) <b>BURIAL</b>  | 23b. DATE<br><b>11/26/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arbutus Mem. Pk.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arbutus, Md.</b>        |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Wm. C. March F/H</b> ADDRESS <b>1101 E. North Ave.</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>                      |  |

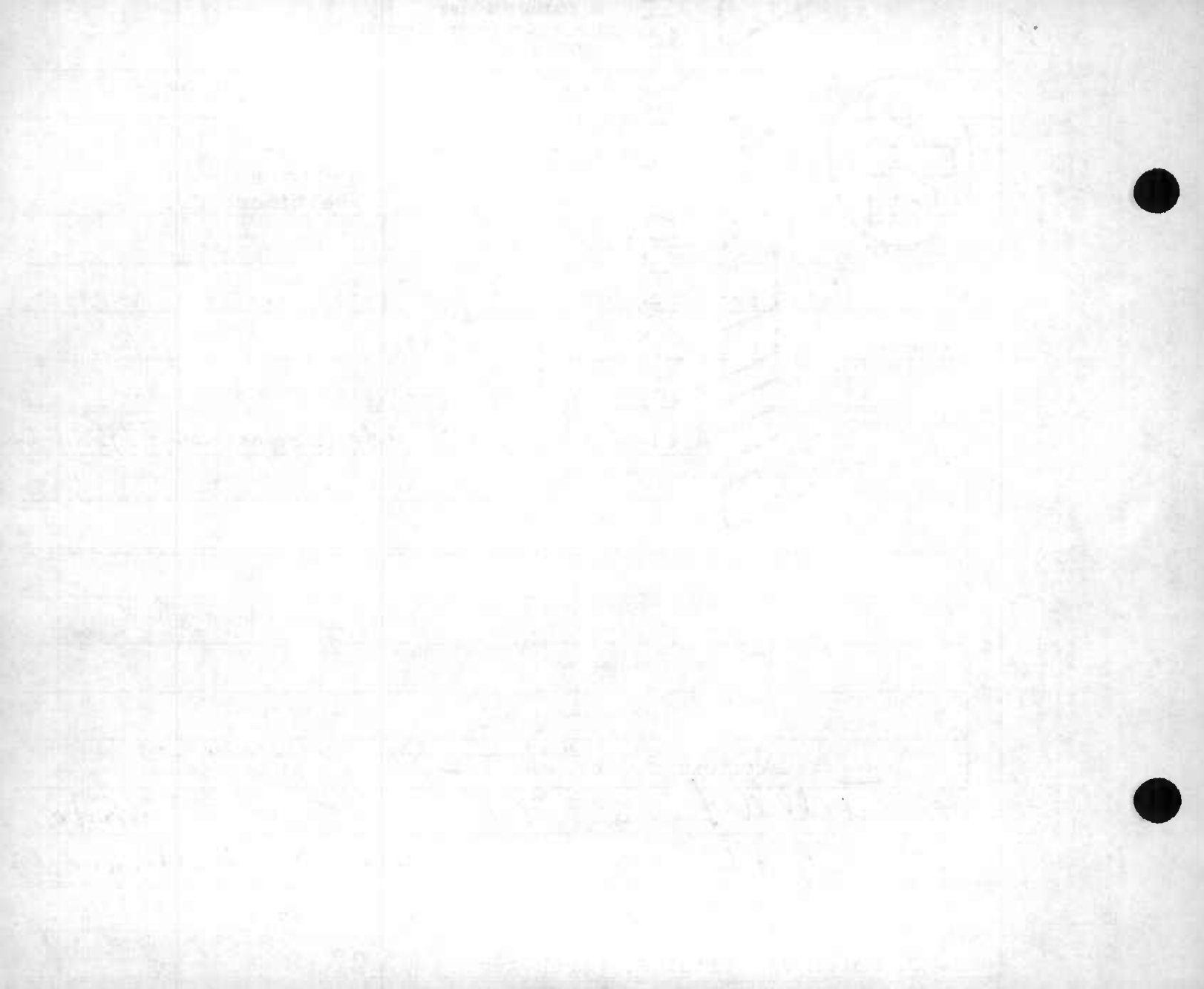
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FOR STATE  
HEALTH DEPT.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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|  |                              |   |  |   |
|--|------------------------------|---|--|---|
| 1. DECEASED-NAME<br>(Type or Print) <b>First Middle Last</b><br><b>Matt James Johnson</b>  |                              |   | 2a. DATE KNOWN OF ESTI-<br>DEATH MATED <input checked="" type="checkbox"/> <b>Nov. 21, 1983</b> 2 <sup>nd</sup> HOUR <b>PM</b> |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>      | 5. DATE OF BIRTH<br><b>MARCH 18, 1921</b>   | 6. AGE (In years last birthday)<br><b>62</b> YRS.  | 7c. DATE PRONOUNCED DEAD<br>Month <b>11</b> Day <b>21</b> Year <b>1983</b> 2 <sup>nd</sup> HOUR <b>PM</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Tenn.</b>  |                              | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 9. COUNTY OF DEATH<br><b>Baltimore County</b>   |
| 10. CITY OR TOWN OF DEATH<br><b>Owings Mills</b>   |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>11240 Liberty Rd.</b>  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>LABORER</b> |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |                              | 13b. CITY OR TOWN<br><b>Owings Mills</b>  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |
| 14. FATHER'S NAME<br><b>First Middle Last</b><br><b>Milum Franklin Johnson</b>   |                              | 15. MOTHER'S MAIDEN NAME<br><b>First Middle Last</b><br><b>Cornia Dell Maness</b>   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>   |                              | 16b. SOCIAL SECURITY NO.<br><b>231 12 7452</b>  |  | 17. INFORMANT ADDRESS<br><b>Rena Johnson - Owings Mills, Md.</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 acute myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |                              |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Immediate</b>  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |                              |   |  |   |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. <b>19</b>  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)                           |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                              |   |  |   |
| ACTUAL SIGNATURE<br><b>Stanley Z. Felsenberg</b>   |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>11/22/83</b>   |
| EXAMINER'S NAME (Type)<br><b>Stanley Z. Felsenberg M.D.</b>  |                              | ADDRESS (Street, city, town, or county)<br><b>11 E. Chase St.</b>   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE<br><b>11-25-83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lake View Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Lysenuth Md. Carroll</b>                              |
| 24. FUNERAL DIRECTOR<br><b>Harry W. Haight</b>   |                              | ADDRESS<br><b>Lysenuth, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>NOV 22 1983</b>  |
|  |                              | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |   |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 24 hours after death.



CLIPPER

CLIPPER

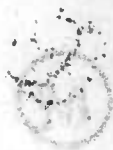
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |   |  |   |   |  |
|---|--|---|---|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR  |  |   |   |   | REG. NO.  |  |   |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>MACKELVY E. JONES</b>   |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11 08 83</b>               |  | 2b. HOUR<br><b>A M</b>  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>03 26 08</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75 YRS.</b>  |   | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>                           |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>LANSDOWNE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>115 WINIFRED ROAD, 21227</b> |   |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WESTINGHOUSE</b>  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13c. CITY OR TOWN<br><b>LANSDOWNE</b>   |   | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>115 WINIFRED AVENUE, 21227</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>LEMUEL JONES</b>  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>LYDA HAMMETT</b>   |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>  |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>705-03-5136</b>  |   | 17. INFORMANT ADDRESS<br><b>CHARLES E. JONES 7932 ROXBURY DRIVE, 21061 GLEN BURNIE, MD.</b>  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis &amp; Cerebrovascular</i><br><b>4373</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) <i>Ischemic Heart Disease</i><br>(c) <i>Valvular Heart Disease</i><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |   |   |   |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)               |   |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>10/16</i> 19 <i>83</i> , to <i>11/08</i> 19 <i>83</i> , that (1) (we) lost <i>see the deceased alive</i> <i>above</i> , (2) (we) (did) <i>not</i> <i>not</i> view the body after death.   |  |   |   |   |   |  |   |   |  |
| 22b. SIGNATURE <i>John C. Healy</i> DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |   |   |   | 22c. DATE SIGNED <i>11/08/83</i>   |   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JOHN C. HEALY, M.D.</b>   |  |   |   |   |   | 22e. ADDRESS<br><b>1311 FRANCIS AVENUE, 21227</b>  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>11-11-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE MEM. PK.</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>ELKBRIDGE HOWARD MARYLAND</b> |   |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229</b>  |  |   |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Corbett</i>  |  |

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |                              |   |   |  |  |  |                 |  |                 |          |  |
|--|------------------------------|---|---|--|--|--|-----------------|--|-----------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |                              | FIRST   | MIDDLE  | LAST   | 2a. DATE OF DEATH  |  | MONTH           | DAY  | YEAR            | 2b. HOUR |  |
| ANNA   |                              |   |   | JOYNER   | 11-3-83  |  |                 |  |                 | 2:24A M  |  |
| 3. SEX   | 4. RACE                      |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))                                |  | IF UNDER 1 YEAR |  | IF UNDER 24 HRS |          |  |
| FEMALE   | BLK                          |   | 09 DAY 01 YEAR  |  | 43 YRS   |  | MONTHS          |  | DAYS            |          | HOURS MIN.                                   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)   | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                             |  |                 |  |                 |          |  |
| N.C.   | USA                          |   |   |  | BALTIMORE CO. MD.  |  |                 |  |                 |          |  |
| 10. CITY OR TOWN OF DEATH  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) |  |                 | 12b. KIND OF BUSINESS OR INDUSTRY                              |                 |          |  |
| Baltimore  |                              | Baltimore Co. General Hosp  |   |  |  |  |                 |  |                 |          |  |
| 13a. STATE   |                              | 13b. COUNTY   |   | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?                                 |                 | 13e. STREET ADDRESS / ZIP CODE                                 |                 |          |  |
| Md   |                              | BAL CITY  |   | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  |  |                 | 1708 N. ELLAMONT ST. 21216                                     |                 |          |  |
| 14. FATHER'S NAME  |                              | 15. MOTHER'S MAIDEN NAME  |   |  |  |  |                 |  |                 |          |  |
| James  |                              | ELVA  |   |  |  |  |                 |  |                 |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |                              | 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT  |  | ADDRESS  |                 |  |                 |          |  |
| NO   |                              |   |   | Glossie Joyner   |  | 1708 N. ELLAMONT ST.                                     |                 |  |                 |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest 2° to<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) acute respiratory failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Sepsis. |                              |   |   |  |  |  |                 |  |                 |          | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |                              |   |   |  |  |  |                 |  |                 |          |  |
| 19a. DATE OF OPERATION   |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                 |          |  |
|  |                              |   |   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/> |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                 |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |  |                 |  |                 |          |  |
|  |                              |   |   |  |  |  |                 |  |                 |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |  |                 |  |                 |          |  |
|  |                              |   |   |  |  |  |                 |  |                 |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-24-1983, to 11-3-1983, that (I) (we) last saw the deceased alive on 11-3-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |                              |   |   |  |  |  |                 |  |                 |          |  |
| 22b. SIGNATURE   |                              |   |   | DEGREE   |  |  |                 | 22c. DATE SIGNED   |                 |          |  |
| R. M. Shah. M.D.   |                              |   |   |  |  |  |                 | 11-3-83  |                 |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |                              |   |   | 22e. ADDRESS   |  |  |                 |  |                 |          |  |
| R. M. SHAH.  |                              |   |   | Baltimore County General Hospital PANDAWHWN. MD.                               |  |  |                 |  |                 |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |                              | 23b. DATE   |   | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE               |                 |  |                 |          |  |
| Burial   |                              | 11/9/83   |   | Mt. Auburn Ceme  |  | Baltimore Md.  |                 |  |                 |          |  |
| 24. FUNERAL DIRECTOR<br>NAME   |                              |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR                            |                 | 25b. REGISTRAR'S SIGNATURE                                     |                 |          |  |
| VIERNON BALIEY 1348 CALHOUN ST   |                              |   |   |  |  | NOV 7 1983   |                 | John J. Carver   |                 |          |  |

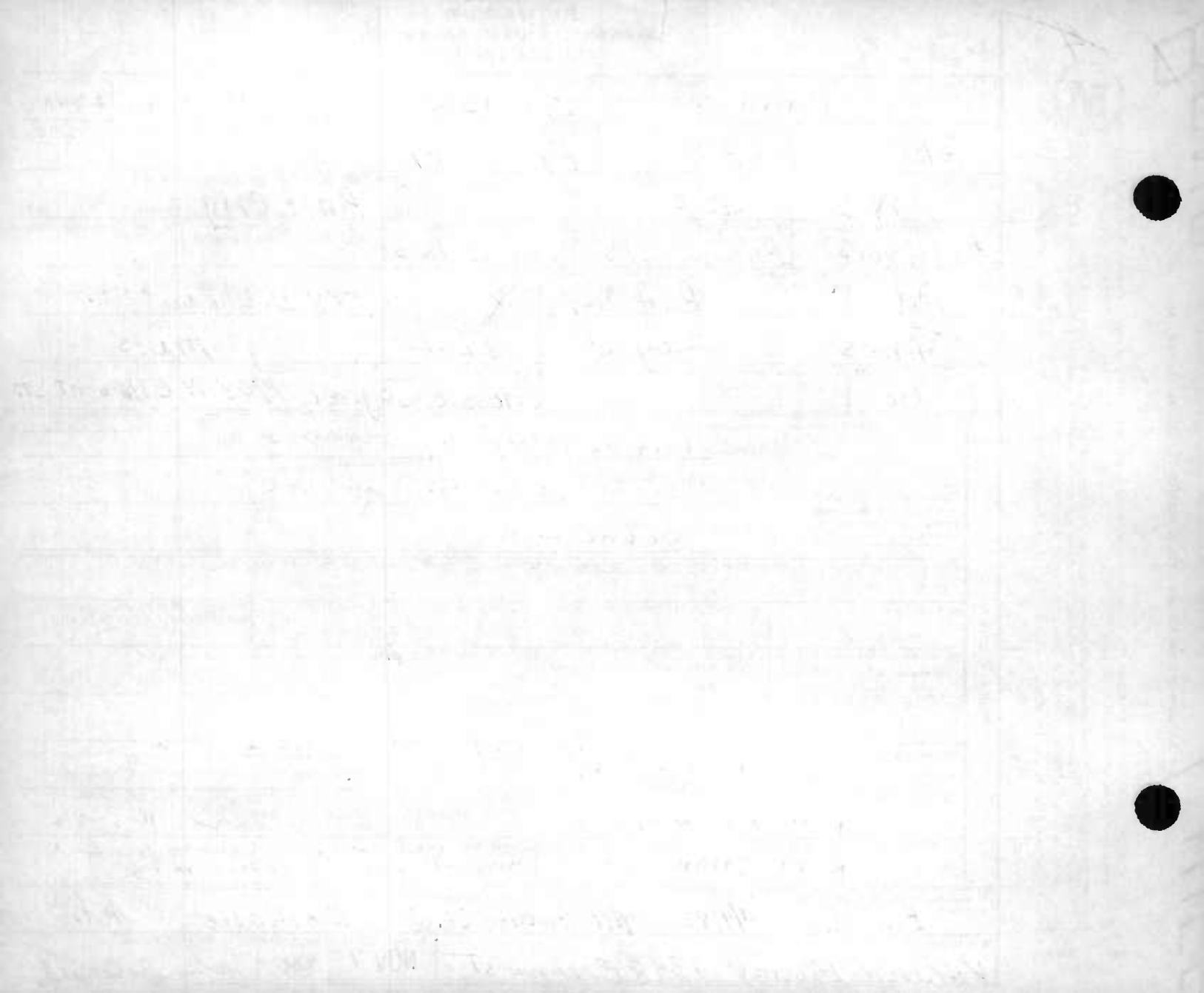
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA E. KALAMAN</b>   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 8, 1983</b>  |  | 2b. HOUR<br><b>9:00 P.</b>   |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 24, 1906</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Dulaney Towson Nursing Home</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>   |  | 13c. CITY OR TOWN<br><b>Glen Arm</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Michael Metro</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Kosztak</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-16-4407 D</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Louise K. Lantz 5703 Williams Rd. 21082</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>4409 Renal failure</b><br>IMMEDIATE CAUSE (a) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Generalized arteriosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Senile brain syndrome</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>5/25/79</b> to <b>11/8/83</b> , that (1) (we) lost saw the deceased alive on <b>10-29-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Donald O. Wood</b>  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11/8/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald O. Wood, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>2 Greenmeadow Drive; Timonium, Md.</b>   |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11-11-1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Maryland</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc. Towson, Maryland</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>San J. Carver</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1- FOR STATE REGISTRAR XC 13640130

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |   |  |   |   |
|---|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WALTER KAMINSKI</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>NOVEMBER 20, 1983</b>  |   | 2b. HOUR<br>M                             |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>APRIL 12, 1890</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>93</b>   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>POLAND</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD                                       |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>V.A.M.C., FORT HOWARD, MARYLAND</b> |   | 12a. USUAL OCCUPATION<br>(IN NON-SEASONAL FACILITY OR STREET VENDOR WORKING LIFE)<br><b>LONGSHOREMAN</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>MARYLAND</b> |   | 13b. COUNTY<br><b>BALTIMORE</b>   | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          |   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>STANISLAUS KAMINSKI</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>FRANCES GROGINSKI</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>YES WW I</b>                                |   | 16b. SOCIAL SECURITY NO.<br><b>217 03 3176</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>CLINICAL RECORDS VAMC, FORT HOWARD, MARYLAND</b> |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>ASHD</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>DIABETES TYPE II</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|--|--|

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)      |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 17</b> , 19 <b>83</b> , to <b>NOVEMBER 20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>NOVEMBER 20</b> , 19 <b>83</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Piero G. Autuono MD</b>  |  |  |  | 22c. DATE SIGNED<br><b>11/21/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>PIERO AUTUONO, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>V.A.M.C., FORT HOWARD, MARYLAND 21052</b>                         |  |

|  |                                |  |   |
|--|--------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  | 23b. DATE<br><b>11/23/1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY ROSARY</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTIMORE MD</b> |
| 24a. FUNERAL DIRECTOR<br>NAME<br><b>RAYMOND L. KACZOROWSKI</b> |                                | 24b. ADDRESS<br><b>2525 FLEET ST.</b>                    |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1983</b>            |                                | 25b. REGISTRAR'S SIGNATURE<br><b>P. G. Autuono</b>       |   |

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DECEMBER 12, 1930

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

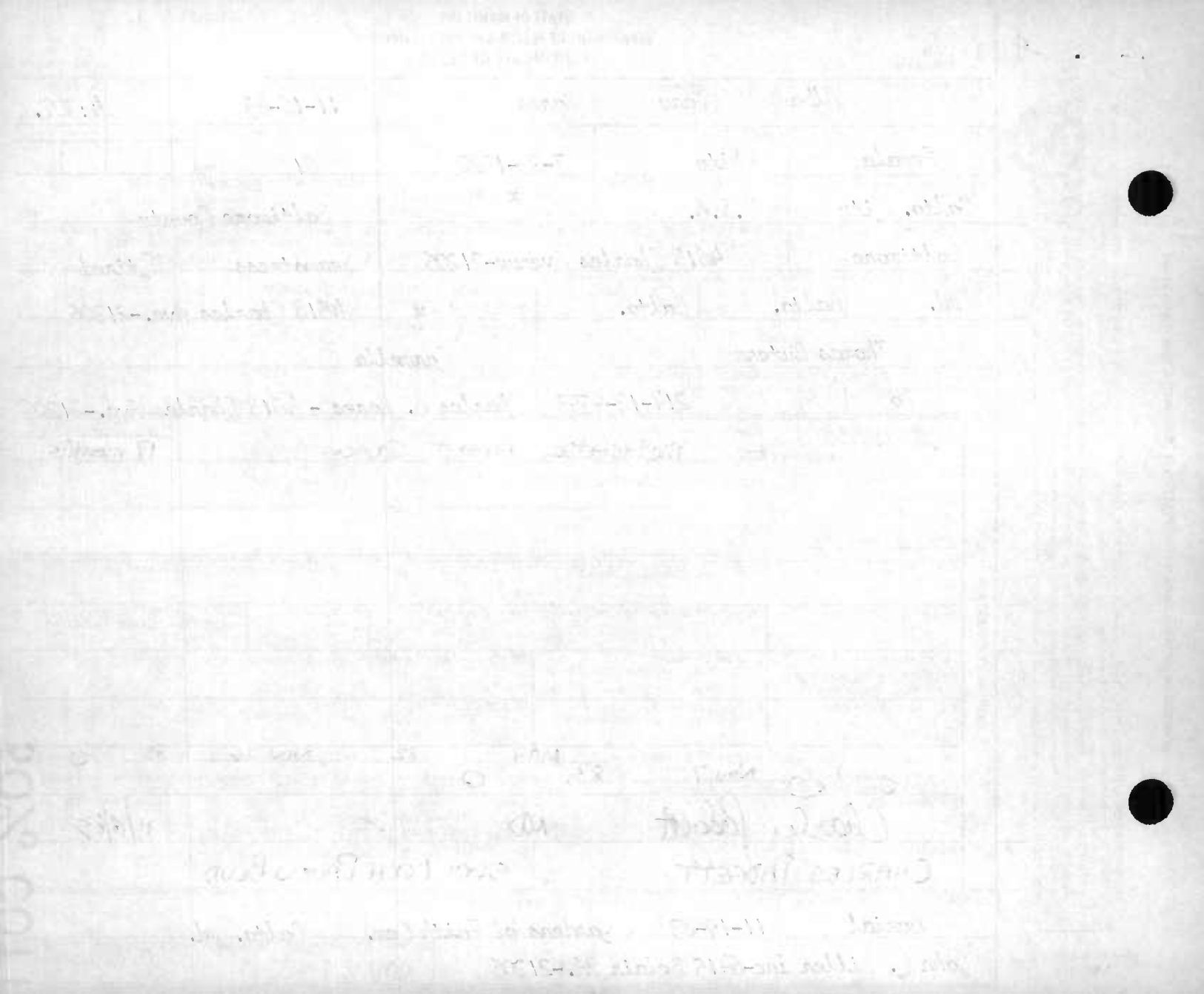
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Alba Mary Kares</i>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11-16-83</i>   |  |  |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>7-22-1922</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>61</i> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Balto. City</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Baltimore</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>4618 Charles Avenue-21206</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Seamstress</i>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Retired</i>  |  |
| 13a. STATE<br><i>Md.</i>   |  | 13b. COUNTY<br><i>Balto.</i>  |  | 13c. CITY OR TOWN<br><i>Balto.</i>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Thomas Butera</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Carmella</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>  |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><i>214-12-9553</i>   |  | 17. INFORMANT<br>ADDRESS<br><i>Charles A. Kares - 4618 Charles Ave. - 21206</i>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Metastatic Breast Cancer</i><br><i>1749</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>17 months</i> |  |   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>82</i> , to <i>Nov 16</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>Nov 7</i> 19 <i>83</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Charles Padgett</i>   |  |   |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>11/18/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>CHARLES PADGETT</i>  |  |   |  | 22e. ADDRESS<br><i>5601 LOCH RAVEN BLVD</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11-19-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Gardens of Faith Cem</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Balto. Md.</i>  |  |
| 24. FUNERAL DIRECTOR<br><i>John C. Miller Inc-6415 Belair Rd.-21206</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 21 1983</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Lohr</i>  |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>S. JEANETTE KELLEY   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>November 19, 1983                  |   |  | 2b. HOUR<br>7 P.M.   |  |   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>July 19, 1895   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>88 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Balto. Co. Md.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.                            |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Dulaney Towson Nursing Home |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Balto.  |  | 13c. CITY OR TOWN<br>Lutherville  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>11604 Kelley Ave. 21093  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Joshua G. Mays  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sallie Tracey  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  |  |  | 16b. SOCIAL SECURITY NO.<br>220-20-0524   |  | 17. INFORMANT ADDRESS<br>Mr. William A. Kelley Cockeysville, Md.                     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u><br>4292 DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MI</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke &amp; Tuberc Bone Disease</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 Days 5 1/2 yrs 1 1/2 yrs |  |  |  |   |  |  |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 Oct 83</u> , 19 <u>83</u> , to <u>19 Nov 83</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>19 Nov 83</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.      |  |  |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><u>[Signature]</u><br>THE PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>11/19/83                                   |   |  |
| 22d. ADDRESS  |  |  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>11/22/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Saters Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Lutherville, Md. |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Eline Funeral Home Reisterstown, Md.  |  |  |  |   | 25a. DATE AND PLACE OF REGISTRATION<br>NOV 21 1983 REGISTRAR'S SIGNATURE <u>[Signature]</u>  |  |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



*[Faint, illegible handwritten text]*

*[Faint, illegible handwritten text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and ready by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 28895   |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST   |  |  | 2b. HOUR M   |  |  |
| EDNA MAY KELLY   |  |  | 11 16 83   |  |  |
| 3. SEX   |  | 4. RACE  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                      |
| Female   |  | White  | Oct. 17, 1925  |  | 58 YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                 |
| Maryland   |  | U.S.A.   |  |  | Baltimore County, MD                                 |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |  |
| Towson   |  | Dulaney Towson Nursing Home  |  | Production Western Electric  |  |
| 13a. STATE   |  |  | 13b. CITY OR TOWN  | 13c. STREET ADDRESS  |  |
| Maryland   |  |  | Baltimore  | 5633 Sagra Road 21239  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |
| Millard Kelly  |  |  | Mary Richardson  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  | 17. INFORMANT ADDRESS  |  |  |
| No   |  |  | Dorothy E. Misterka 5633 Sagra Rd. 21239   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 Cardio Respiratory  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Month |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Failure from Metastatic Cancer  |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |
|  |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |
|  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 Sept 1983 to 16 Nov 1983, that (I) saw the deceased alive on 16 Nov 1983, and that in my opinion death occurred on the date and hour and from the causes stated above, (I) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  | 22c. DATE SIGNED   |  |
| Charles F. O'Donnell   |  |  |  | 11/16/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS   |  |
| Charles F. O'Donnell, M.D.   |  |  |  | 7501 York Road Towson, Md. 21204   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | Nov 21 1983  |  | Glen Haven Memorial  |  |
|  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
|  |  |  |  | Glen Burnie Maryland   |  |
| 24. FUNERAL DIRECTOR NAME  |  |  | 25a. DATE REC'D. BY REGISTRAR  |  |  |
| Leonard J. Ruck, Inc. Baltimore, Maryland  |  |  | NOV 21 1983  |  |  |
|  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
|  |  |  | [Signature]  |  |  |

Richard J. Buck, Inc., Baltimore, Maryland

Nov 21 1983 Glen Haven Hospital

Glen Haven

Mar 1984

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HELEN H. KENDALL   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 20, 1983 |   |  | 2b. HOUR<br>12:35 P.   |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Nov. 23, 1901   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>81 YRS  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Virginia   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>St. Joseph Hospital |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore   |  | 13c. CITY OR TOWN<br>21234  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Sadie Able  |  | 17. INFORMANT<br>ADDRESS<br>Margaret V. Swigon 21234<br>1711 Wycliffe Ave.  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>218-28-0151   |  | 17. INFORMANT<br>ADDRESS<br>Margaret V. Swigon 21234<br>1711 Wycliffe Ave.  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Shock<br>5990<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Gram Negative Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) Urinary Tract Infection<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>6 Hrs<br>18 Hrs |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a<br>CONGESTIVE HEART FAILURE  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10, 19 82, to 11, 19 83, that (I) (we) lost saw the deceased alive on 11-16-19-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br>Simon V. Scalia M.D.  |  | DEGREE<br>M.D.   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11-21-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Simon Scalia, M.D.   |  | 22e. ADDRESS<br>11722 Reisterstown Road 833-5000   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Cremation   |  | 23b. DATE<br>Nov. 22, '83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Green Mount Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore, Maryland  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>William E. Johnson  |  | ADDRESS<br>8521 Loch Raven Blvd.   |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 21 1983  |  |  |  |

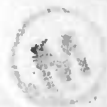
BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





9022-269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ELIZABETH KERNES</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 13 83</b> |   |  | 2b. HOUR<br><b>6:00 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 21 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>(GBMC) 6701 NORTH CHARLES STREET</b>  |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>AT Home</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>BALTIMORE</b> 13c. CITY OR TOWN <b>CARNESY</b> |  |   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William B. HAIGHT</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>JENNIE VRELAND</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13e. STREET ADDRESS / ZIP CODE<br><b>2815 SUPERIOR AVE. 21234</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-22-1278</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>FAMILY RECORDS</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |  |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>10-29</b> , 19 <b>83</b> , to <b>11-13</b> , 19 <b>83</b> , that (1) <input checked="" type="checkbox"/> saw the deceased alive on <b>11-13</b> , 19 <b>83</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input checked="" type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Thomas C. Detweiler MD</b>  |  | DEGREE<br><b>MD</b>  |  |   |  | 22c. DATE SIGNED<br><b>11-13-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>THOMAS C. DETWEILER, MD.</b>   |  | 22e. ADDRESS<br><b>6701 NORTH CHARLES STREET</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>Nov. 16, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>TIMONUM BALTO. MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>EVANS (CHAP) OF MEMORIES HARBOR</b>   |  | ADDRESS<br><b>8800</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>  |  |

MEDICAL CERTIFICATION

11 13 10:00

HEWLETT

ELIZABETH

RECEIVED 11 13 10:00

CLINTON COUNTY

(FBI)

101 NORTH CHARL STREET

TOWNS

AT THE JUDICIAL DEPARTMENT

CONSTITUTIONAL RIGHTS

10 23 11 15

11 13

11-13-13

101 NORTH CHARL STREET

THOMAS C. GUTWILLER, MD.





20% COTTON  
FLEXA



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |
|--|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Ethel M. Killens  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 3 83  |   | 2b. HOUR<br>M  |
| 3. SEX<br>Female   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>11 18 1909  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>Maryland   | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.                      |  |
| 10. CITY OR TOWN OF DEATH<br>Dundalk   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>1819 Kinship Road |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Domestic Helper             |   | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Dundalk |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Albert Bull  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Charlotte Chalk                                |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>214-22-7193  |   | 17. INFORMANT<br>ADDRESS<br>Donald L. Kidwell 1819 Kinship Road Balto., MD. 21222 |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 4100 Acute Myocardial Infarction  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  
(b) HASCD  
DUE TO, OR AS A CONSEQUENCE OF  
(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 day  
20 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

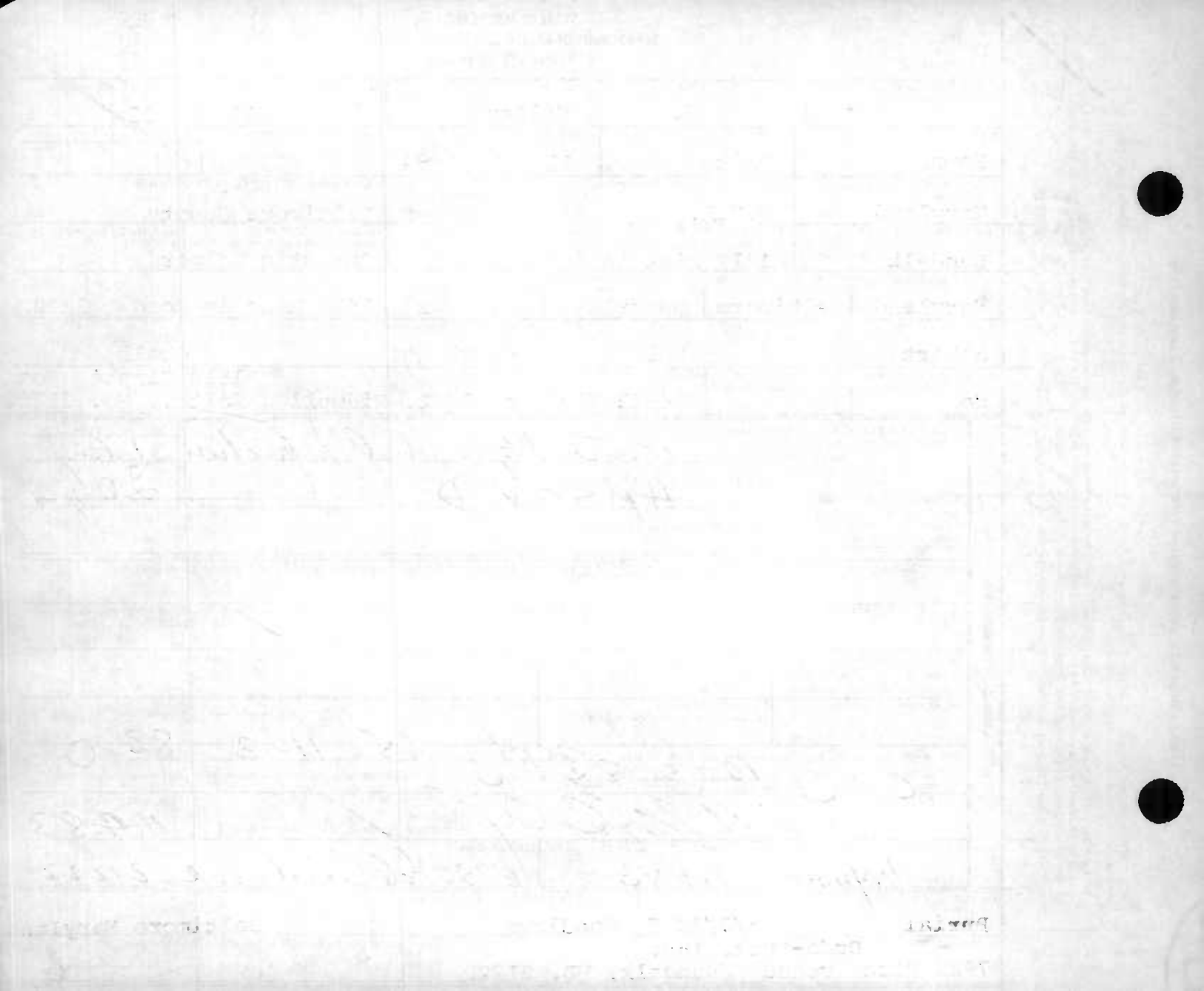
|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 10-3</u> , 19 <u>65</u> , to <u>11-3</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>10-3-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  |  |  |
| 22b. SIGNATURE<br><u>Wyman Wong</u>  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED<br><u>11-9-83</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>Wyman Wong</u>   | 22e. ADDRESS<br><u>16730 Holabird Ave 21222</u>  |  |  |

|  |                        |  |  |
|--|------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial                                 | 23b. DATE<br>11/7/1983 | 23c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Maryland |
| 24. FUNERAL DIRECTOR<br>NAME<br>Duda-Ruck, Inc.<br>7922 Wise Avenue Dundalk, MD. 21222 |                        | 25a. DATE REC'D. BY REGISTRAR<br>NOV 8 1983    | 25b. REGISTRAR'S SIGNATURE<br><u>J. J. Conner</u>                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called into action.





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

|  |                         |  |   |   |   |
|--|-------------------------|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHRISTOPHER CLAY KING</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED<br>MONTH DAY YEAR<br><b>11 2 19 83</b> |   | 2b. HOUR<br>M<br><b>9:50</b><br>P M   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>11 - 13-1963</b>  | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br><b>19 YRS.</b>                      | IF UNDER 1 YR.<br>MONTHS DAYS<br><b>19</b>  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>19</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |                         | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph's Hospital</b> |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Student</b>   |   |
| 13a. STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>Baltimore</b>  |   | 13c. CITY OR TOWN<br><b>Lutherville</b>   |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Charles E. King, Jr.</b>  |                         | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Diana L. Lowenstein</b>  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>217-90-5908</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Charles E. King, Jr. - Same as #13e</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4254 IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u></b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                         |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |                         |  |   |   |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                         | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                         |  |   |   |   |
| ACTUAL SIGNATURE<br><b>Ann M. Dixon</b>  |                         | TITLE (SPECIFY)<br>M.D. <b>Assistant</b> MEDICAL EXAMINER  |   | DATE SIGNED <b>11-3-83</b>  |   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Ann M. Dixon, M.D.</b>  |                         | ADDRESS<br><b>111 Penn St., Balto., Md. 21201</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |                         | 23b. DATE<br><b>11-5-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Ruck Towson Funeral Home, Inc.</b>  |                         | ADDRESS<br><b>Towson, Md. 21204</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Timonium Balto. Md.</b>  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1983</b>   |                         | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |   |

White 11 - 11-1963 19

U.S.A.

Student

1900 Wexford St. - 21003

Lowenstein

Charles E. King, Jr. - Same as file

217-92-1008

11-1-63

1950 York St.  
The Townson, N.Y. 11204

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

28901

FOR  
1- STATE  
REGISTRAR

REG. NO.

|   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><u>Margaret R. Kirklewski</u> |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><u>11 30 1983</u><br>2b. HOUR<br><u>11:05 PM</u> |   |   |
| 3. SEX<br><u>Female</u>   | 4. RACE<br><u>White</u>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><u>5 20 1908</u>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><u>75</u> YRS.                                       |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><u>USA PA</u>                             | 7b. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><u>Baltimore County</u> MD. |   |
| 10. CITY OR TOWN OF DEATH<br><u>Baltimore</u>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><u>Saint Joseph's Hospital</u> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><u>Canteen Work</u> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><u>8</u>                   |

|   |                                 |   |   |  |  |
|---|---------------------------------|---|---|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) |                                 |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 13a. STATE<br><u>MD</u>   | 13b. COUNTY<br><u>Baltimore</u> | 13c. CITY OR TOWN<br><u>Ft. Howard</u>  | 13e. STREET ADDRESS / ZIP CODE<br><u>7520 Blank Ave 21052</u>                                   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><u>Roy Clever</u>                             |                                 |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><u>Lettie Cloak</u>                            |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><u>Unknown</u>  |                                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><u>210-20-1714</u> | 17. INFORMANT<br>ADDRESS<br><u>Wallace J. Kirklewski-Balto, MD. 21052</u>                       |  |  |

|  |  |  |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Brain Tumor (Cystic glioma)</u><br><u>2396</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 mos</u> |
|--|--|--|

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>      | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11-24-83</u> to <u>11-30-83</u> , that (I) (we) last saw the deceased alive on <u>11-24-83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE<br><u>W. K. Worke</u>  |  | DEGREE<br><u>MD</u>  |  | 22c. DATE SIGNED<br><u>11-30-83</u>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>W. K. Worke</u>   |  | 22e. ADDRESS<br><u>6730 Holabird Ave Balto Md</u>                      |  |  |  |

|   |                               |   |   |
|---|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><u>Burial</u>   | 23b. DATE<br><u>12/5/1983</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Meadowridge</u>  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><u>Dorsey Howard Maryland</u> |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Duda-Ruck, Inc.</u><br>ADDRESS<br><u>7922 Wise Avenue Dundalk, MD. 21222</u> |                               | 25a. DATE REC'D. BY REGISTRAR<br><u>DEC 5 1983</u><br>25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u> |   |

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and a table. The table has columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.

| Date       | Description | Amount |
|------------|-------------|--------|
| 10/10/1917 | ...         | ...    |
| 10/11/1917 | ...         | ...    |
| 10/12/1917 | ...         | ...    |
| 10/13/1917 | ...         | ...    |
| 10/14/1917 | ...         | ...    |
| 10/15/1917 | ...         | ...    |
| 10/16/1917 | ...         | ...    |
| 10/17/1917 | ...         | ...    |
| 10/18/1917 | ...         | ...    |
| 10/19/1917 | ...         | ...    |
| 10/20/1917 | ...         | ...    |
| 10/21/1917 | ...         | ...    |
| 10/22/1917 | ...         | ...    |
| 10/23/1917 | ...         | ...    |
| 10/24/1917 | ...         | ...    |
| 10/25/1917 | ...         | ...    |
| 10/26/1917 | ...         | ...    |
| 10/27/1917 | ...         | ...    |
| 10/28/1917 | ...         | ...    |
| 10/29/1917 | ...         | ...    |
| 10/30/1917 | ...         | ...    |
| 10/31/1917 | ...         | ...    |

Handwritten notes and a table. The table has columns for 'Date', 'Description', and 'Amount'. The text is mostly illegible due to fading.

| Date       | Description | Amount |
|------------|-------------|--------|
| 11/1/1917  | ...         | ...    |
| 11/2/1917  | ...         | ...    |
| 11/3/1917  | ...         | ...    |
| 11/4/1917  | ...         | ...    |
| 11/5/1917  | ...         | ...    |
| 11/6/1917  | ...         | ...    |
| 11/7/1917  | ...         | ...    |
| 11/8/1917  | ...         | ...    |
| 11/9/1917  | ...         | ...    |
| 11/10/1917 | ...         | ...    |
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| 11/14/1917 | ...         | ...    |
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| 11/19/1917 | ...         | ...    |
| 11/20/1917 | ...         | ...    |
| 11/21/1917 | ...         | ...    |
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| 11/25/1917 | ...         | ...    |
| 11/26/1917 | ...         | ...    |
| 11/27/1917 | ...         | ...    |
| 11/28/1917 | ...         | ...    |
| 11/29/1917 | ...         | ...    |
| 11/30/1917 | ...         | ...    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be given to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |  |   |
|--|--|---|--|---|--|--|---|--|---|
| 1. FOR STATE REGISTRAR   |  |   |  |   | REG. NO.   |  |   |  |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>FREIDA KLEIN</b>   |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 27 83</b><br>2b. HOUR<br><b>8:55 P.M.</b> |  |   |  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 17 1894</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>89</b><br>YRS.                                 |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>8 55 P.M.</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD.                  |   |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Pikesville</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Pikesville Nursing Home</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>housewife</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>homemaking</b>   |   |
| 13a. STATE<br><b>Maryland</b>  |  |   |  |   | 13b. CITY OR TOWN<br><b>Baltimore</b>  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Witt</b>   |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>N/A</b>                            |  |   |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |   |  |   | 16b. SOCIAL SECURITY NO.<br><b>220-12-4353</b>   |  | 17. INFORMANT<br><b>Jean Donaldson</b>  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b>                           |  |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |   |  |  |   |  |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)         |  |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.   |  |   |  |   |  |  |   |  |   |
| 22b. SIGNATURE<br><b>Harold Bob</b>  |  |   |  |   | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-28-83</b>                 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Harold Bob</b>   |  |   |  |   | 22e. ADDRESS<br><b>7220 Park Heights Ave 21208</b>                                     |  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |   | 23b. DATE<br><b>11-29-83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>                         |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b>  |  |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lassahn Funeral Home</b>  |  |   |  |   | 24b. ADDRESS<br><b>7401 Belair Rd. Balto., Md. 21236</b>                               |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b> |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST MIDDLE LAST<br><b>JOSEPHINE K. KLIPNER Klipner</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>11/29/83</b>   |  | 2b. HOUR<br><b>5:00P<sub>M</sub></b>  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 21 1903</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>80</b>  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY MD</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>6701 N CHARLES ST GBMC</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Kingsville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 13e. STREET ADDRESS / ZIP CODE<br><b>10042 Gunridge Circle 21087</b>   |  | 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Joseph Klima</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary ? ?</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>213-34-0253</b>   |  | 17. INFORMANT ADDRESS<br><b>Mr Charles F Klipner Jr Same As 13e</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b><br><b>1536</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>CARCINOMA OF RIGHT COLON</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 WEEKS</b><br><b>6 WEEKS</b> |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>11/18/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>INTESTINAL OBSTRUCTION</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/8 83</b> to <b>11/29 83</b> , that (I) (we) lost the deceased alive on <b>11/29 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Richard Moskowitz</b>   |  | DEGREE<br><b>MD</b>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br><b>11/30/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR R MOSKOWITZ</b>   |  | 22e. ADDRESS<br><b>GBMC</b>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>12/3/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Leonard J Ruck Inc. Baltimore, Maryland</b>   |  | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 1 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION



11 28 63 2:00P

WESLEY E. KILMER

BALTIMORE COUNTY

6701 W. CHARLES ST. BALTO.

WYOMING



GWEENS

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CARD 11 OF 12512

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211 W. BROAD ST.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a copy of the law, see the regulations of the Department of Health and Mental Hygiene, page 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>HENRY W. KOCH, Jr.  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11-23-83 |   |  | 2b. HOUR<br>5:55 PM   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>8 29 12   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Maryland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore Co. MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Randallstown  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Balto. Co. Gen. Hospital |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Ice Co.  |  |
| 13a. STATE<br>Md.  |  | 13b. COUNTY<br>Balto.   |   | 13c. CITY OR TOWN<br>Owings Mills   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Henry William Koch   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Loretta Jacob  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>218-07-2682   |  |
| 17. INFORMANT<br>Ann Koch  |  | 17. ADDRESS<br>11021 Reisterstown Rd.<br>Owings Mills, Md 21117   |   | 17. ADDRESS<br>11021 Reisterstown Rd.<br>Owings Mills, Md 21117   |  | 17. ADDRESS<br>11021 Reisterstown Rd.<br>Owings Mills, Md 21117   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) LIVER INSUFFICIENCY 2° TO<br>5715 } DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which } (b) CIRRHOSIS } LIVER.<br>gave rise to immediate }<br>cause (a), stating the }<br>underlying cause last. }<br>(c) |  |   |   |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK                  |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   | 21g. LOCATION<br>CITY OR TOWN COUNTY STATE  |  | 21h. LOCATION<br>CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-8-1983, to 11-23-1983, that (I) (we) last saw the deceased alive on 11-23-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |   |   |   |  |   |  |
| 22b. SIGNATURE<br>R.M. SHAH M.D.   |  | DEGREE  |   | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>                  |  | 22c. DATE SIGNED<br>11-23-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R.M. SHAH, M.D.   |  | 22e. ADDRESS<br>Bal. County Gen. Hospital<br>Randallstown, MD 21133   |   | 22f. ADDRESS<br>Bal. County Gen. Hospital<br>Randallstown, MD 21133   |  | 22g. ADDRESS<br>Bal. County Gen. Hospital<br>Randallstown, MD 21133   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 26, 1983  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>All Saints Cem.   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Reisterstown Balto. Md  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>H. F. Schmitt  |  | ADDRESS<br>Owings Mills, Md.  |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 28 1983   |  | REGISTRAR'S SIGNATURE<br>John J. Conner   |  |

MEDICAL CERTIFICATION



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>GERTRUDE N. KOEHLER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 18, 1983 |   |  | 2b. HOUR<br>M  |  |
| 3. SEX<br>F   |  | 4. RACE<br>W  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Feb. 9, 1912  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Pennsylvania   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County MD.   |  |
| 10. CITY OR TOWN OF DEATH<br>Towson   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Greater Baltimore Medical Center |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker  |  |
| 13a. STATE<br>Maryland  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Phoenix  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William E. Neilson  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Maude Schaefer   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br>217-48-9790   |  | 17. INFORMANT<br>George W. Koehler  |  |   |  | ADDRESS<br>Same  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u><br>4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 YEARS</u> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>HYPERTENSION - SINCE 1975</u>  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-18, 1979</u> , to <u>11-18, 1983</u> , that (I) (we) last saw the deceased alive on <u>10-28, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><u>J. R. Norris</u>   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>     |  | 22c. DATE SIGNED<br>11-18-83  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John R. Norris, M.D.   |  | 22e. ADDRESS<br>3421 Sweet Air Rd. Phoenix, MD 21131  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 21, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Dulaney V lley  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Timonium, Balto. Co., Md.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>MITCHELL-WIEDEFELD HOME, INC.   |  | ADDRESS<br>6500 York Rd.  |  | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><u>John J. Smith</u>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COMMUNICATIONS SECTION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or called.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |
|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME (TYPE OR PRINT)   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
|   |  | Andrew J. KOZYCKI,   |  | Nov. 11, 1983  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| Male  |  | Cauc.  |  | 09 30 '83  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Maryland  |  | U.S.A.   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Perry Point, MD   |  | VA MEDICAL CENTER  |  | Comm. Officer  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS / ZIP CODE   |  | 13b. CITY OR TOWN  |  |
| Gov't.  |  | 6941 Eastbrook Ave. 21224  |  | Baltimore  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |
| Stanley Kozycki   |  | Mary Baran   |  | yes  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |
| 213 07 6770   |  | Mrs. Mary Kozycki - 6941 Eastbrook Av. 21224   |  | PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4100   |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease  |  |
|   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung Disease  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
|   |  | P.M. 19  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
|   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/07, 1983, to 11/11/1983, that (I) (we) lost saw the deceased alive on 11/11, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Eugene A. Jaeger MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 11/11/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |
| EUGENE A JAEGER MD  |  | VAMC Perry Point, MD   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial  |  | 11/15/83   |  | Catonsville Veterans   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Walter Dabrowski Funeral Home   |  | 1005 Dundalk Ave Dundalk, Md.  |  | NOV 17 1983  |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE   |  |
|   |  |  |  | John J. Connel   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |  |  |  |  |
|---|--|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>CHRISTINE M. KRATZMEIER</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 18 '83</b> |   |  | 2b. HOUR<br><b>10:25<sup>A</sup></b>   |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Oct. 16, 1904</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b> YRS.                                    |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pa.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY, MD.</b>                 |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Bondix</b>   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Balto.</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>4501 White Avenue, 21206</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Edward Spioer</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Naomi Lindenbooth</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>102-03-2535</b>                                       |  | 17. INFORMANT<br>ADDRESS<br><b>Bernard Kratzmerier, 4501 White Ave. 21206</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>ACUTE MYOCARDIAL INFARCTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |   |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)  |  |  |   |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11/17</b> , 19 <b>83</b> , to <b>11/18</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11/18</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                           |  |  |   |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>James H. Biddison</b>  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>11/18/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES BIDDISON, M.D.</b>  |  |  |   | 22e. ADDRESS<br><b>6301 N. CHARLES STREET BALTO. MD 21212</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/21/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Centre County Mem. Park, Bellesfont, Pa.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Joseph N. Zannino, 263 S. Conkling Street</b>  |  |  |   | ADDRESS<br><b>21254</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 22 1983</b>                                  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |  |   |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |  |  |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Eldora E. Kuhl</b>  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>Nov. 13 83</b>               |   |  | 2b. HOUR<br><b>1:35 PM</b>  |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>3 19 06</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Florida</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                              |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>13 Rambling Oaks Way</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>   |   | 13c. CITY OR TOWN<br><b>Catonsville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. BALTIMORE ADDRESS<br><b>Balto., Md. #21228</b><br><b>13 Rambling Oaks Way</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Thomas Bevil</b>  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Addie</b>          |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br><b>215-46-6819</b>                      |   |  | 17. RESIDENT ADDRESS<br><b>6529 Redgate Circle Balto., Md. #21228</b><br><b>Albert L. Kuhl</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br><b>4100</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Aortic Disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>1969</b>  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>1/15/83</b>   |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>           |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>2/13/83</b> 19 <b>83</b> , to <b>11/13/83</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>11/13/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Cliff Ratliff, Jr.</b> MD  |  |  |   |   |  | DEGREE<br><b>MD</b>   |  | 22c. DATE SIGNED<br><b>11/14/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>CLIFF RATLIFF, JR.</b>  |  |  |   |   |  | 22e. ADDRESS<br><b>5722 West View Mall, 21228</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>Nov. 16, 1983</b>                                   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Pk. Cem.</b> |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>   |  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1983</b>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |  |   |   |  |   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.   |  |   |  |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><i>Bertha Kuzak</i>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>11/16/83</i>   |  |  |  | 2b. HOUR<br><i>1:30 PM</i>   |  |   |  |
| 3. SEX<br><i>Female</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>10/01/07</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>76</i> YRS   |  | IF UNDER 1 YEAR MONTHS DAYS  |  | IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Mo.</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>BALTO CO</i> MD.                                  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>BALTO.</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Armacost Nurs. Home</i> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY                                      |  |   |  |
| 13a. STATE<br><i>md</i>  |  | 13b. COUNTY<br><i>BALTO.</i>  |  | 13c. CITY OR TOWN<br><i>BALTO.</i>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><i>21224 2317 Fleet Street</i>       |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |   |  | 16b. SOCIAL SECURITY NO.<br><i>213-18362</i>  |  | 17. INFORMANT ADDRESS<br><i>812 Regester Ave. Baltimore, Md 21239</i>                        |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Coronary Artery Sudden</i><br><i>4292</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCVD</i><br>DUE TO, OR AS A CONSEQUENCE OF (c) <i>57 yrs</i>   |  |   |  |   |  |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)   |  |   |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)               |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5/15</i> , 19 <i>83</i> , to <i>11/16</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>4/10/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Charles O'Donnell</i>   |  |   |  | DEGREE<br><i>MD</i>   |  |  |  | 22c. DATE SIGNED<br><i>11/16/83</i>                                    |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Charles O'Donnell</i>  |  |   |  | 22e. ADDRESS<br><i>7501 YORK Rd BALTO MD 21204</i>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>BURIAL</i>   |  |   |  | 23b. DATE<br><i>11-19-83</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>St. Orlawa</i>                                      |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>BALTO Mo.</i>            |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br><i>TACOROVSKI FUNERAL HOME</i>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><i>NOV 18 1983</i>   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Linnick</i>                   |  |   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                     |  |  |   |  |
|---|---------------------|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John C. Lauer</b>  |                     | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-8-83</b>  |  | 2b. HOUR<br><b>5:33pm</b>   |  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9-2-1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>69</b> YRS.                                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>                                    |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                 |  |
| 10. CITY OR TOWN OF DEATH<br><b>TOWSON</b>  |                     | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN BALTIMORE CITY OR COUNTY, GIVE ADDRESS)<br><b>ST JOSEPH HOSPITAL</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b> |  |
| 13a. STATE<br><b>MD.</b>  |                     | 13b. COUNTY<br><b>BALTO.</b>   |  | 13c. CITY OR TOWN<br><b>BALTO.</b>  |  |
| 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                     | 13e. STREET ADDRESS / ZIP CODE<br><b>2904 OAKCREST AVE. 21234</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DEPT. STORE</b>                             |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FREDERICK B. LAUER</b>                             |                     | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>AUGUSTA P. MATTHAI</b>   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>               |                     | 16b. SOCIAL SECURITY NO.<br><b>213-03-1920</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Nancy J. Opnel - 4407 Harcourt Rd. 21214</b>    |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1: DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4100**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.(b) **Cardiogenic Shock**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ASCA**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**3 hrs.****" "****2 1/2 hrs.**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11-8</b> , 19 <b>83</b> , to <b>11-8</b> , 19 <b>83</b> , that (we) lost<br>saw the deceased alive on <b>11-8</b> , 19 <b>83</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated<br>above, (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. PHYSICIAN'S SIGNATURE<br><b>John Messina</b>   |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/9/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>John Messina, M.D.</b>  |  | 22e. ADDRESS<br><b>7620 York Road Towson, M.D. 21204</b>               |  |  |  |   |  |

|   |  |                              |  |  |  |   |  |
|---|--|------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>                    |  | 23b. DATE<br><b>11-11-83</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKWOOD GEN.</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Valleyville - 7527 Harford Rd.</b> |  |                              |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 9 1983</b>         |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Lauer</b>              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

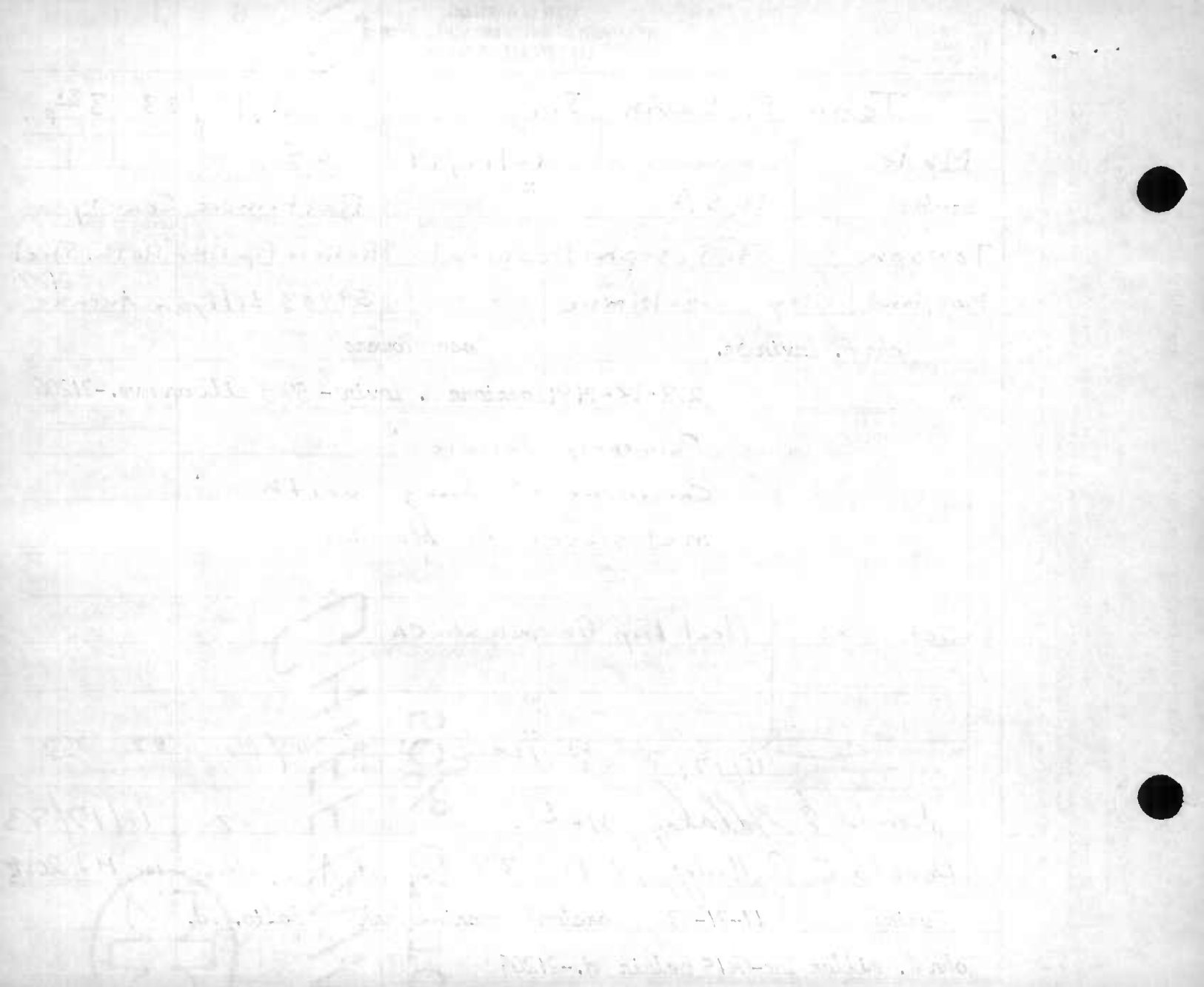
|   |  |  |   |   |   |  |  |  |  |
|---|--|--|---|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>John F. Lavin Jr.</b>  |  |  | 2a. DATE OF DEATH<br>MONTH <b>11</b> / DAY <b>17</b> / YEAR <b>83</b>                   |   |   | 2b. HOUR<br><b>3:31</b> P.M.   |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Caucasian</b>  |   | 5. DATE OF BIRTH<br>MONTH <b>12</b> / DAY <b>19</b> / YEAR <b>14</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> / DAYS <b>0</b> / HOURS <b>0</b> / MIN. <b>0</b>  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>                                  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>St. Joseph's Hospital</b> |   |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Pipe Fitter</b>          |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. CITY OR TOWN<br><b>City Baltimore</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br><b>59 03 Lillyan Avenue 21206</b>   |  |  |  |
| 14. FATHER'S NAME<br>FIRST <b>John F.</b> MIDDLE <b>Lavin Sr.</b> LAST  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Rose</b> MIDDLE <b>Powers</b> LAST   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>218-18-1459</b>   |   | 17. INFORMANT ADDRESS<br><b>Lorriane M. Lavin - 5903 Lillyan Ave. - 21206</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Failure</b><br><b>1629</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Carcinoma of lung with</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(c) <b>metastases to bladder</b><br>DUE TO, OR AS A CONSEQUENCE OF |  |  |   |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |   |   |  |  |  |  |
| 19a. DATE OF OPERATION<br><b>Oct. 83</b>  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>ileal loop for metastatic CA</b> |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <b>19</b>                       |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                       |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                  |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) this hospital attended the deceased from <b>11/16</b> 19 <b>83</b> to <b>11/17</b> 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>11/17</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.   |  |  |   |   |   |  |  |  |  |
| 22b. SIGNATURE<br><b>Donald E. Golladay M.D.</b>  |  |  |   |   |   | DEGREE<br><b>M.D.</b>  |  | 22c. DATE SIGNED<br><b>11/17/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Donald E. Golladay, M.D.</b>  |  |  |   |   |   | 22e. ADDRESS<br><b>3701 Dupont Ave., Kensington, Md. 20885</b>                                       |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b>  |  |  | 23b. DATE<br><b>11-21-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b> |  | 23d. LOCATION<br>CITY OR TOWN <b>Balto. Md.</b> COUNTY STATE |  |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>John C. Miller Inc-6415 Belair Rd.-21206</b> ADDRESS  |  |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>NOV 21 1983</b> <b>John J. Carver</b> |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | REG. NO.  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ROBERT LAWS</b>  |  | 2a. DATE OF DEATH MONTH <b>11</b> DAY <b>12</b> YEAR <b>83</b>  |  |
| 3. SEX <b>MALE</b>   |  | 2b. HOUR <b>10:10P<sub>M</sub></b>  |  |
| 4. RACE <b>BLACK</b>   |  | 5. DATE OF BIRTH MONTH <b>1</b> DAY <b>9</b> YEAR <b>1922</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.  |  |
| 7b. CITIZEN OF WHAT COUNTRY? <b>US</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>    |  |
| 10. CITY OR TOWN OF DEATH <b>BALTIMORE</b>   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>BALTIMORE</b> MD.   |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>VAMC BALTIMORE, MARYLAND 21218</b>  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CARPENTER</b>  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY  |  |   |  |
| 13a. STATE <b>MARYLAND</b>   |  | 13b. CITY OR TOWN <b>BALTIMORE</b>  |  |
| 13c. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13d. STREET ADDRESS / ZIP CODE <b>1940 W. LANVALE ST. 21217</b>   |  |
| 14. FATHER'S NAME FIRST <b>ALPHEUS</b> MIDDLE LAST <b>LAWS</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST <b>SUSIE</b> MIDDLE LAST <b>NICKENS</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>   |  | 16b. SOCIAL SECURITY NO. <b>225 20 6042</b>   |  |
| 17. INFORMANT ADDRESS <b>AUDREY JOHNSON 1940 W. LANVALE ST. 21217</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Multisystem failure / Malnutrition</b><br><b>1419</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Squamous cell carcinoma - Tongue</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Smoking</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b><br><b>1+ yrs.</b>  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>OCTOBER 21</b> , 19 <b>83</b> , to <b>NOVEMBER 12</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) lost above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.   |  |   |  |
| 22b. SIGNATURE <b>M. B. Applestein</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  |
| 22c. DATE SIGNED <b>11/13/83</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MARIE B. Applestein</b>   |  | 22e. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>  |  | 23b. DATE <b>11-18-83</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>CROWNSVILLE VET.</b>   |  | 23d. LOCATION <b>CROWNSVILLE</b> COUNTY <b>MARYLAND</b> STATE   |  |
| 24. FUNERAL DIRECTOR NAME <b>E.L. PHILLIPS</b>   |  | 25a. DATE REC'D. BY REGISTRAR <b>NOV 14 1983</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>  |  |   |  |

BER

DOWN



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>ANNA M. LAWSON</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 13, 1988</b>  |  | 2b. HOUR<br><b>4:50 P</b>  |   |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 8, 1905</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Balto., Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St. Joseph Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Saleslady - Dept. Store</b>                         |   |
| 13a. STATE<br><b>Md</b>  |  | 13b. CITY OR TOWN<br><b>Baltimore</b>   |  | 13c. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. STREET ADDRESS / ZIP CODE<br><b>414 N. Lakewood Ave. 21224</b>  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William - Alexander</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Carrie - Smith</b>  |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>206-24-6671</b>  |  | 17. INFORMANT <b>Baltimore, Md. 21224</b><br><b>Mrs. Carole L. Griggs-127 N. Linwood Ave.</b>   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO PULMONARY ARREST</b><br><b>4240</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>CONGESTIVE HEART FAILURE</b><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) <b>RHEUMATIC VALVULAR (MITRAL) HEART DISEASE</b><br><b>YEARS</b> |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>45 min</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a   |  |   |  |   |  |  |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |
| 22a. I certify that (this hospital) attended the deceased from <b>11-7-83</b> , to <b>11-13-83</b> , that (we) last saw the deceased alive on <b>11-13-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (did) not view the body after death.  |  |   |  |   |  |  |   |
| 22b. SIGNATURE<br><b>Jorge C. Secada-Lovio, MD</b>   |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  | 22c. DATE SIGNED<br><b>11-13-83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JORGE C. SECADA-LOVIO, MD</b>  |  |   |  | 22e. ADDRESS<br><b>ST. JOSEPH HOSPITAL TOWSON, MD. 21204</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11/16/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>   |  | 23d. LOCATION<br><b>Baltimore, Maryland</b> STATE  |   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John A. Moran, Inc. Funeral Home 3000 E. Baltimore St.; Balto., Md. 21224</b>   |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>NOV 15 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Jorge C. Secada-Lovio</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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St. Joseph Hospital

St. Joseph Hospital

St. Joseph Hospital

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St. Joseph Hospital

St. Joseph Hospital

St. Joseph Hospital

St. Joseph Hospital

St. Joseph Hospital



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

DECEASED NAME  
(TYPE OR PRINT)FIRST  
EstherMIDDLE  
G.LAST  
LEADER

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
November 15, 1983 10:00am

3. SEX

F

4. RACE

WHITE

5. DATE OF BIRTH

DEC. 14 1908

6. AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE

MD.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Baltimore County

10. CITY OR TOWN OF DEATH

ESSEX

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

FRANKLIN Sq. Hosp.

12a. USUAL OCCUPATION

HOUSEWIFE

12b. KIND OF BUSINESS OR

INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD.

13b. COUNTY

BALTO.

13c. CITY OR TOWN

DUNDALK

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

3536 McSHANE WAY 21222

14. FATHER'S NAME

CHARLES F. SCHELLER

15. MOTHER'S MAIDEN NAME

DELMA HARN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

(IF YES, GIVE WAR OR DATES)

215-34-8496

17. INFORMANT

CHARLES E. LEADER 21220

ADDRESS

3713 HURLOCK DR.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4360

IMMEDIATE CAUSE (a)

Cerebrovascular Accident

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (this hospital) attended the deceased from November 3, 19 83, to November 15, 19 83, that (we) last

saw the deceased alive on November 15, 19 83, and that in (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

DEGREE

MD

ATTENDING

MEDICAL

STAFF

22c. DATE SIGNED

11/15/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

SALZBERG

22e. ADDRESS

9000 Franklin Square Drive 21237

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

11-18-83

23c. NAME OF CEMETERY OR CREMATORY

BELAIR MEA. GARDENS

23d. LOCATION

CITY OR TOWN

HARTFORD CO. MD.

24. FUNERAL DIRECTOR

HOFFMANN - SKARDA 3218 HUDSON ST.

25a. DATE REC'D. BY REGISTRAR

NOV 17 1983

25b. REGISTRAR'S SIGNATURE

John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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CHIEF OF POLICE

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

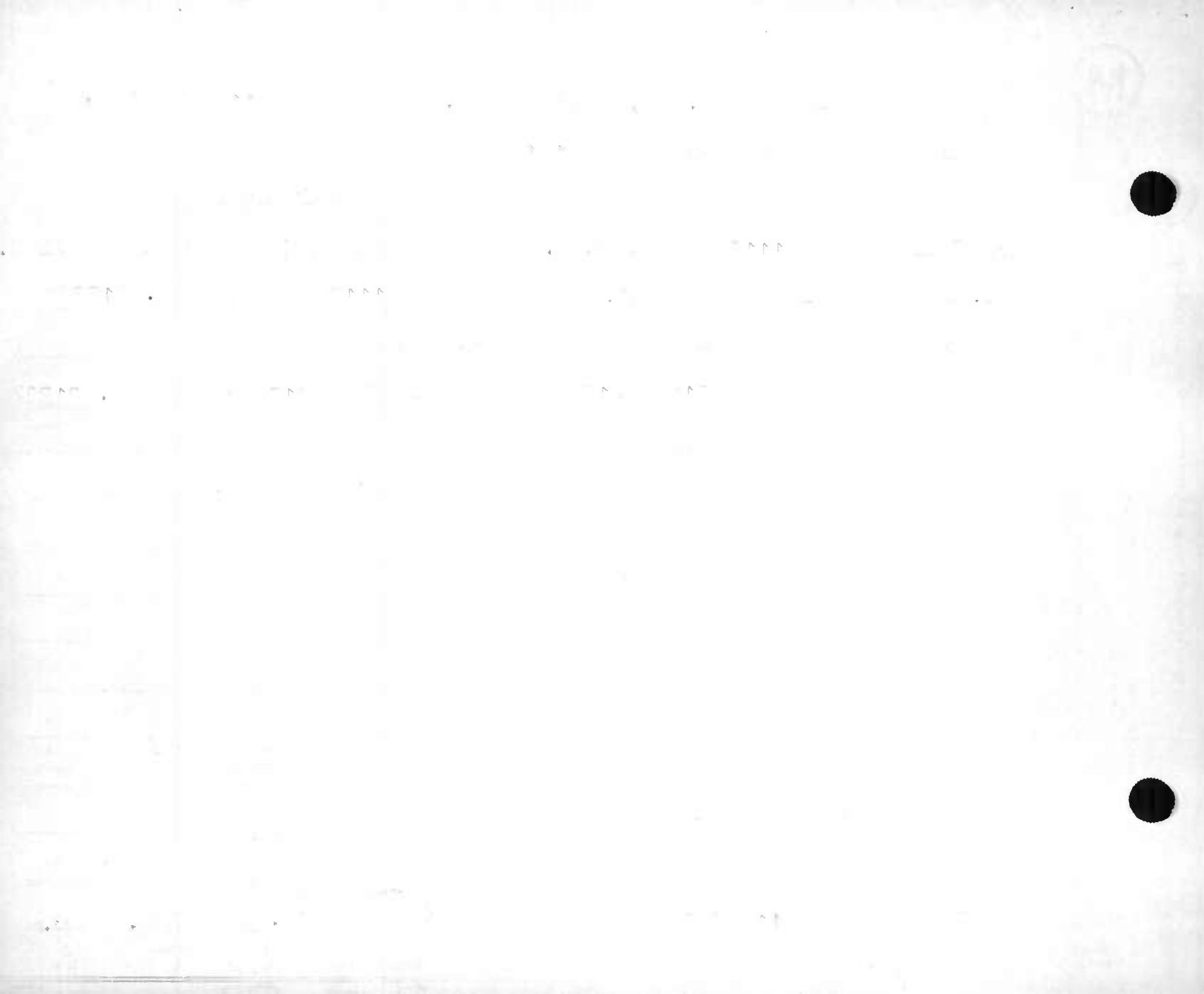
|  |  |   |  |   |   |   |  |  |   |  |
|--|--|---|--|---|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>JOSEPH J. LEHNER SR.</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11 04 83</b>                 |   |   | 2b. HOUR<br><b>1 P M</b>  |  |  |   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>01 10 08</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>75</b> YRS.   |  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                             |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSEDALE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>1113 CHESACO AVE.</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>MACHINIST</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>WESTERN ELEC.</b>  |   |  |
| 13a. STATE<br><b>MARYLAND</b>  |  | 13b. COUNTY<br><b>BALTIMORE</b>   |  | 13c. CITY OR TOWN<br><b>ROSEDALE</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  | 13e. STREET ADDRESS<br><b>1113 CHESACO AVE. 21237</b> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>JOHN LEHNER</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>KATHERINE ZAPP</b>  |   |   |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>216095812</b>  |   | 17. INFORMANT ADDRESS<br><b>RAYMOND LEHNER 8012 DuVALL AVE. 21237</b>                           |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Negative metastasis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Circumstances of duodenal</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>6 min.</u><br><u>6 yr</u>   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |   |   |   |  |  |   |  |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> , 19 <u>83</u> , to <u>11/14</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>10/26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                    |  |   |  |   |   |   |  |  |   |  |
| 22b. SIGNATURE<br><u>Francis D. Milligan</u><br>DEGREE   |  |   |  |   |   | 22c. DATE SIGNED  |  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>FRANCIS D. MILLIGAN</b>  |  |   |  |   |   | 22e. ADDRESS<br><b>11 E CHASE ST, BALTIMORE 21202</b>   |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |   | 23b. DATE<br><b>11/7/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b> |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. BALTO. MD.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><u>Francis D. Milligan</u> ADDRESS<br><u>1211 Chesaco Ave.</u>   |  |   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 7 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Gairick</u>   |   |  |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |  |  |   |  |
|---|--|---|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>SIDNEY L. LEVY</b>  |  |   | 2a. DATE OF DEATH<br>MONTH <b>11</b> DAY <b>30</b> YEAR <b>83</b> |   |  | 2b. HOUR<br><b>10 55 AM</b>  |  |   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASION</b>   |   | 5. DATE OF BIRTH<br>MONTH <b>12</b> DAY <b>01</b> YEAR <b>94</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b> YRS.                                    |  | 7. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.                  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>RANDALLSTOWN</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>BALTIMORE COUNTY GEN. HOSP.</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>SALESMAN</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>SHOES</b>   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>BALTIMORE</b>   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>3916 FORDLEIGH RD.</b>                                     |  | 13f. CITY OR TOWN<br><b>BALTO.</b>  |  |
| 14. FATHER'S NAME<br>FIRST <b>WOLF</b> MIDDLE <b>LEVY</b> LAST <b>LEVY</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>ANNIE</b> MIDDLE <b>LEVY</b> LAST <b>LEVY</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>577-05-2977</b>                                       |  | 17. INFORMANT<br><b>MRS. CAROLYN NOEL</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b><br><b>4860</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PNEUMONIA</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |   |   |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>—</b> <b>—</b> <b>—</b> <b>19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>11-14-1983</b> to <b>11-30-1983</b> , that (I) (we) last saw the deceased alive on <b>11-30-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |   |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>[Signature]</b>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |  |  | 22c. DATE SIGNED<br><b>11-30-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>DR. SUDHIR D. PATEL</b>   |  |   |   | 22e. ADDRESS<br><b>BAL. COUNTY GEN. HOSP.</b>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  | 23b. DATE<br><b>DEC. 1, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HAR ZION TIFERETH ISRAEL</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROSEDALE BALTO. MD</b>              |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>SOL LEVINSON &amp; BROS., INC.</b><br>ADDRESS <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>                                     |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 indicates any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST<br><b>ELIZABETH S. LEWIS</b>   |  |  |  | November 12, 1983   |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 24 13</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Balto. County MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Edgemere</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>35A Loring Court, 21219</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Baltimore</b>  |  | 13c. CITY OR TOWN<br><b>Edgemere</b>  |  | 13e. STREET ADDRESS / ZIP CODE<br><b>35-A Loring Court 21219</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>James Cavey</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Mary Swan</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>216-80-0961</b>   |  | 17. INFORMANT<br><b>Bruce N. Beasley</b>  |  | ADDRESS<br><b>35-A Loring Ct. Balto., MD. 21219</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>1629</b> DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Lung Cancer</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>15 mins.</b><br><b>2 1/2 mths.</b> |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>10</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>Sept 11 1983</b> to <b>Nov 11 1983</b> , that (1) (we) lost saw the deceased alive on <b>Nov 11 1983</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If true) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Albert L. Blumberg</b>   |  |  |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                          |  | 22c. DATE SIGNED<br><b>11/14/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Albert Blumberg, M.D.</b>   |  |  |  | 22e. ADDRESS<br><b>Greater Baltimore Medical Center</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>11/16/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Glen Burnie Maryland</b>  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Duda-Ruck Funeral Home, Inc. Dundalk, Md. 21222</b>   |  |  |  | 7922 Wise Ave.<br>ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 17 1983</b>   |  |
|   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Schick</b>   |  |   |  |



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pattie D. LEWIS</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 26, 1983</b>                      |  | 2b. HOUR<br><b>4:40 a.m.</b>  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 26, 1900</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>83</b> YRS                                     | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>North Carolina</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD                   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rosedale</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |
| 13a. STATE<br><b>Maryland</b>  |   |   | 13b. COUNTY<br><b>-Baltimore</b>   | 13c. CITY OR TOWN<br><b>Baltimore</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                       |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>John Dunn</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Susan Evans</b>                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>241-62-8256</b>  |  | 17. INFORMANT (Son) ADDRESS<br><b>Bruce Lewis Rt.#2 Whitakers, N.C.</b>              |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br><b>4850</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF (c)   |   |   |  |  |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Meningioma</b>   |   |   |  |  |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)        |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 11, 1983</b> to <b>November 26, 1983</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> saw the deceased alive on <b>November 26, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) (did) (not) view the body after death. |   |   |  |  |   |
| 22b. SIGNATURE<br><b>L. A. Labib</b>   |   | DEGREE<br><b>Labib A. Labib, M.D.</b>   |  | 22c. DATE SIGNED<br><b>11.26.83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |   | 22e. ADDRESS  |  |  |   |
| <b>Labib A. Labib, M.D.</b>  |   | <b>9000 Franklin Square Drive, 21237</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  | 23b. DATE<br><b>11/28/83</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Hill Cem.</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Nashville Nash N.C.</b>             |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>E. Barnes</b>   |   | ADDRESS<br><b>21018 Benson, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 29 1983</b>                                  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Bailey</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 12 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |  |   |  |   |  |  |  |
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| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Pauline E Lewis</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-1-83</b>                  |   |  | 2b. HOUR<br><b>2:09pm</b>   |  |  |  |
| 3. SEX<br><b>F</b>   |  | 4. RACE<br><b>W</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>9/6/20</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>63</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>VA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore county</b> MD.                             |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Towson</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>St Joseph hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>IT SWE</b>               |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>MD.</b>   |  | 13b. COUNTY<br><b>MONTEGOMERY</b>  |  | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br><b>828 BOWIE RD 20852</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>FRED COOPER</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>NETTIE WILSON</b>   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>231 48 6267</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>RITA GOLDEN 16 EVERLASTING LN</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BLEEDING ESOPHAGEAL VARICES</b><br><b>5712</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>PORTAL HYPERTENSION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>ALCOHOLIC LIVER CIRRHOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>11-1-83</b>      |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |
| 22a. I certify that (X) (this hospital) attended the deceased from <b>10-18</b> , 19 <b>83</b> , to <b>11-1</b> , 19 <b>83</b> , that (X) (we) lost (X) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Ernest N Arnett, M.D.</b>   |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  |   | 22c. DATE SIGNED<br><b>11-1-83</b>                             |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Ernest N Arnett, M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>7620 YORK ROAD TOWSON MD 21204</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  |  | 23b. DATE<br><b>11/5/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLLY HILL</b>                        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO. MD</b> |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J.G. CONNELLY</b>   |  |  |  | ADDRESS<br><b>300 MACC-</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 14 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelly</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><i>Mary Margaret Liebig</i>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><i>November 1, 1983</i>                     |   | 2b. HOUR<br><i>A.M.</i>  |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>White</i>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>11 22 13</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>69</i> YRS.   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><i>Maryland</i>   | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Baltimore County</i> MD                              |  |
| 10. CITY OR TOWN OF DEATH<br><i>Essex</i>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Riverview Nursing Home</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Retired</i> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Housework</i>  |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Baltimore</i>   | 13c. CITY OR TOWN<br><i>Dundalk</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Albert Green</i>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Bertha Wootton</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><i>No</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>213-01-0606</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>Irma Wilson 68 Shipway 21222</i>                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>acute myocardial infarction</i><br><i>4100</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) <i>ischemic heart disease</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>sudden</i><br><i>5 years</i> |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i></i>  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 29, 1983</i> to <i>1 Nov 83</i> , that (I) (we) lost<br>saw the deceased alive on <i>10-23</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |
| 22b. SIGNATURE<br><i>M. Rainess</i>   |  | DEGREE<br><i>MD</i>   |  | 22c. DATE SIGNED<br><i>11-1-83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MORRIS RAINESS, MD</i>  |  | 22e. ADDRESS<br><i>1105 OLD EASTERN AVE Balto Md. 21221</i>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  | 23b. DATE<br><i>11-3-83</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Oak Lawn Cemetery</i>                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Eastwood, Balto. Co., Md.</i>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>Charles S. Zeiler &amp; Son Inc.</i>   |  | ADDRESS<br><i>901 S. Conkling</i>   |  | 25a. DATE RECD. BY REGISTRAR<br><i>NOV 3 - 1983</i>   |  |
|   |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Rainess</i>  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  | XC29 596 994   |  | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>JACOB WILLIAM LONAS</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>NOVEMBER 3, 1983</b>   |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>APRIL 6 1916</b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VIRGINIA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.<br><b>67 YRS</b>   |  |
| 10. CITY OR TOWN OF DEATH<br><b>FORT HOWARD</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>VA MEDICAL CENTER</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b> MD.   |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>HOWARD</b>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br><b>13d. STREET ADDRESS</b><br><b>3357 N Chatham Rd 21043</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>HARRY LONAS</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>FANNIE GETZ</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Transportation</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>YES</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>217 03 2512</b>   |  | 17. INFORMANT ADDRESS<br><b>CLINICAL RECORDS, VAMC, FORT HOWARD, MD</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br>4360<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SEPTIC SHOCK</b><br><b>SECONDARY TO URINARY TRACT INFECTION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>UNCONTROLLED HYPERTENSION</b>                    |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>17 DAYS</b><br><b>17 DAYS</b><br><b>4 YEARS</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>SEIZURE DISORDER, NON-FUNCTION OF LEFT KIDNEY</b>  |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 1</b> , 19 <b>80</b> , to <b>NOVEMBER 3</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>NOVEMBER 3</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Wen Shyang Wu M.D.</b>   |  |  |  | 22c. DATE SIGNED<br><b>11/3/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Wen Shyang Wu M.D.</b>  |  |  |  | 22e. ADDRESS<br><b>VA MEDICAL CENTER, FORT HOWARD, MD 21052</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>Nov 7, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crest Lawn</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>Harry H Witzke</b>  |  | 24b. ADDRESS<br><b>4112 Columbia Rd Ellicott City</b>  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 4 1983</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John J. Connel</i>   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HARRY H WELLS 4112 Columbia Rd Ellicott City

Nov 7, 1983

Great lawn

Howard Maryland



100% COTTON  
THERMATEX

Transportation

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  | REG. NO.  |  |                |  |
|---|--|---|--|---|--|---|--|---|--|---|--|----------------|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |   |  | 2b. HOUR       |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Viola Jane Long</b>  |  |   |  |   |  | <b>November 19, 1983</b>  |  |   |  |   |  | <b>1:12 pm</b> |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>W</b>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>5/11/04</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>79</b>  |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.   |  |                |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PA.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>   |  |   |  |   |  |                |  |
| 10. CITY OR TOWN OF DEATH<br><b>ROSSVILLE</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FRANKLIN SR.</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H SWE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |                |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>BALTO</b>   |  | 13c. CITY OR TOWN<br><b>ESSEX</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>21221 11 E. ORVILLE RD</b>                              |  |   |  |                |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>WILLIAM BOLLINGER</b>   |  |   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>MABEL UNK</b>  |  |   |  |   |  |                |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>NO</b>  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br><b>216013957</b>  |  | 17. INFORMANT ADDRESS<br><b>OTTS LONG 49 WILTSHIRE RD</b>   |  |   |  |   |  |   |  |                |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br><b>4349</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Brain Infarction in Right Middle Cerebral Artery Distribution</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |   |  |   |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |   |  |   |  |   |  |   |  |   |  |                |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |   |  |                |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK   |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |   |  |                |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 12, 1983</b> , to <b>November 19, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 19, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. |  |   |  |   |  |   |  |   |  |   |  |                |  |
| 22b. SIGNATURE<br><b>W. Rimmer</b>  |  |   |  |   |  | DEGREE<br><b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11/19/83</b>   |  |   |  |                |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Waclaw Kazimierzczak, M.D.</b>  |  |   |  |   |  | 22e. ADDRESS<br><b>9000 Franklin Square Drive, 21237</b>  |  |   |  |   |  |                |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  |   |  | 23b. DATE<br><b>11/24/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>DAK LAWN</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>BALTO. MD.</b>                      |  |   |  |                |  |
| 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>J.G. CONNELLY 300 MACE</b>  |  |   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 23 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelly</b>                             |  |   |  |                |  |

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 26. COMMENT - 300 inches  
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 28. COMMENT - 300 inches  
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 31. COMMENT - 300 inches  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>ALAN G LOPER  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11 04 83 |   |  | 2b. HOUR<br>11:00P   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>WHITE  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>02 08 18  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>65 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>BALTIMORE COUNTY, MD.  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST JOSEPH'S HOSPITAL |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman   |  |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>BALTIMORE  |   | 13c. CITY OR TOWN<br>MARYLAND   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Orrin Loper  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Laura Cole   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>Yes WW II  |  | 16b. SOCIAL SECURITY NO.<br>178-10-0890   |   | 17. INFORMANT<br>Mrs. Joyce K. Loper Same as #13.   |  |  |  |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cardiac Standstill</i><br>1629 DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Acute heart block, high degree</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i>unstable</i> |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>acute</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a<br><i>ASVD Post op 2 med C. lung</i>  |  |   |   |   |  |  |  |
| 19a. DATE OF OPERATION<br>10/20/83   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>C. lung</i>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>6</i> , 19 <i>80</i> , to <i>11 14</i> , 19 <i>83</i> , that (1) (we) last saw the deceased alive on <i>11/4/83</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                                      |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><i>D.A. Oursler</i>  |  |   |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>        |  | 22c. DATE SIGNED<br><i>11/14/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D.A. Oursler</i>   |  |   |   | 22e. ADDRESS<br><i>7401 Osler Dr.</i>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>Nov. 8, 1983   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Oakland Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Warren, Pennsylvania   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Ruck Towson Funeral Home, Inc. Towson, Md. 21204   |  |   |   | 25. DATE REC'D. BY REGISTRAR<br>NOV 7 1983  |  |  |  |
| 26. REGISTRAR'S SIGNATURE<br><i>John J. Grier</i>  |  |   |   |   |  |  |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Dorothy Ellen LUCAS</b> |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>November 18, 1983</b>                         |  | 2b. HOUR<br><b>2:55pm</b>                                       |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 17 1906</b>   |  | 6. AGE (IN YEARS, LAST BIRTHDAY)<br><b>77</b>                      | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County</b> MD |   |
| 10. CITY OR TOWN OF DEATH<br><b>Rossville</b>                  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> | 12b. KIND OF BUSINESS OR INDUSTRY                                  |   |

|  |  |  |   |   |   |
|--|--|--|---|---|---|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE<br><b>Maryland</b> |  | 13b. COUNTY<br><b>Baltimore</b>                | 13c. CITY OR TOWN<br><b>Essex</b>                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS<br><b>1565 A Alconbury Road</b> 21221 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Walter Mullineau</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sally Unknown</b> |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>            |  | 16b. SOCIAL SECURITY NO.<br><b>219-28-8962</b> |   | 17. INFORMANT ADDRESS<br><b>Charles C. Lucas, Jr. 1401 Woodbine Way Woodbine, Md.</b>           |   |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |
| 4148<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic Shock</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Multiple Myocardial Infarctions</b> |  |   |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Chronic Renal Failure**

|   |  |  |  |
|---|--|--|--|
| 19a. DATE OF OPERATION  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 28, 19 83</b> to <b>November 18, 19 83</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 18, 19 83</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> not view the body after death. |  |  |  |

|   |   |                                     |
|---|---|-------------------------------------|
| 22b. SIGNATURE<br><b>James Sides MD</b>                           | DEGREE  | 22c. DATE SIGNED<br><b>11/18/83</b> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Sides, M.D.</b> | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b> |                                     |

|  |                                   |   |  |
|--|-----------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(REGISTRY)<br><b>Burial</b> | 23b. DATE<br><b>Nov. 21, 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Mem. Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Md.</b> |
|--|-----------------------------------|---|--|

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| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Leonard J. Ruck, Inc. Baltimore, Maryland</b> | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1983</b> | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b> |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Leonard J. Buck, Inc. Baltimore, Maryland

Nov. 21, 1987, Maryland News, Inc.

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Jan. 17 1986

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |   |  |   |  |  |
|---|---|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Shirley A. Lucas</b>  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11/23/83</b>   |   | 2b. HOUR<br><b>10:00 P.M.</b>  |  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Black</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>12 27 36</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>47</b> YRS.                                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>BALTO., Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>      |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County Md.</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>House Keeping</b>        |  | 12b. KIND OF BUSINESS OR INDUSTRY                                |
| 13a. STATE<br><b>MARYLAND</b>   | 13b. COUNTY<br><b>Baltimore</b>   | 13c. CITY OR TOWN<br><b>Owings Mill</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE<br><b>7 Stone Mark Ct. 21117</b>                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>PRESTON GRIFFIN</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELIZABETH DOUGLAS</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>NO</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>216-32-1901</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>TOYANNA LUCAS 7 Stone Mark Ct.</b>                    |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b><br><b>4254</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Renal Failure</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery</b> |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>20 MIN.</b>   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Coronary Artery Bypass</b>  |   |  |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 19c. ALTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21a. INJURY OCCURRED<br>WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)   |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>11/23/83</b> to <b>11/23/83</b> and that in my (my) opinion death occurred on the date and hour and from the causes stated.   |   |  |   |  |  |
| 22b. SIGNATURE<br><b>Dr. F. Caplan, M.D.</b>  |   | DEGREE <b>M.D.</b><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>11/23/83</b>  |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Dr. F. Caplan, M.D.</b>   |   | 23b. ADDRESS<br><b>2435 W. Balducci Ave 5215</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |   | 23b. DATE<br><b>11/28/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MT. AUBURN CEM.</b>                                    |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>BALTO., Md.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>LEROY O. DYETT</b>   |   | ADDRESS<br><b>4600 LIBERTY HGTS. AVE.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 25 1983</b>                                  |  |
|   |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Smith</b>                                   |  |

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 3 2 8 7 2 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William Barton LUCAS |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 10, 1983 |   |  | 2b. HOUR<br>1:00pm <sup>M</sup>  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Jan. 20, 1908   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Illinois               |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore County <sup>MD</sup>       |  |
| 10. CITY OR TOWN OF DEATH<br>Rossville 21237                |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>Franklin Sq. Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Salesman |  |
|   |  |  |  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Shoe Co.                                |  |

|   |  |  |   |  |  |  |   |  |   |  |
|---|--|--|---|--|--|--|---|--|---|--|
| 13a. STATE<br>Maryland  |  |  | 13b. COUNTY<br>Baltimore  |  | 13c. CITY OR TOWN<br>Middle River                                |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS / ZIP CODE<br>4 E Mercy Court 21220 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Clarence Barton Lucas             |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Kohlbecker |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>WWII 219 01 3813 |  | 17. INFORMANT<br>ADDRESS<br>Alice Lucas, Wife                    |  |   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1541 IMMEDIATE CAUSE (a) Metastatic Rectal Carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|---|--|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

Status Post Myocardial Infarction With Congestive Heart Failure

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from October 21, 1983, to November 10, 1983, that (we) last saw the deceased alive on November 10, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (not) view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>J. Richter  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>11-10-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Richter   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Drive 21237   |  |  |  |

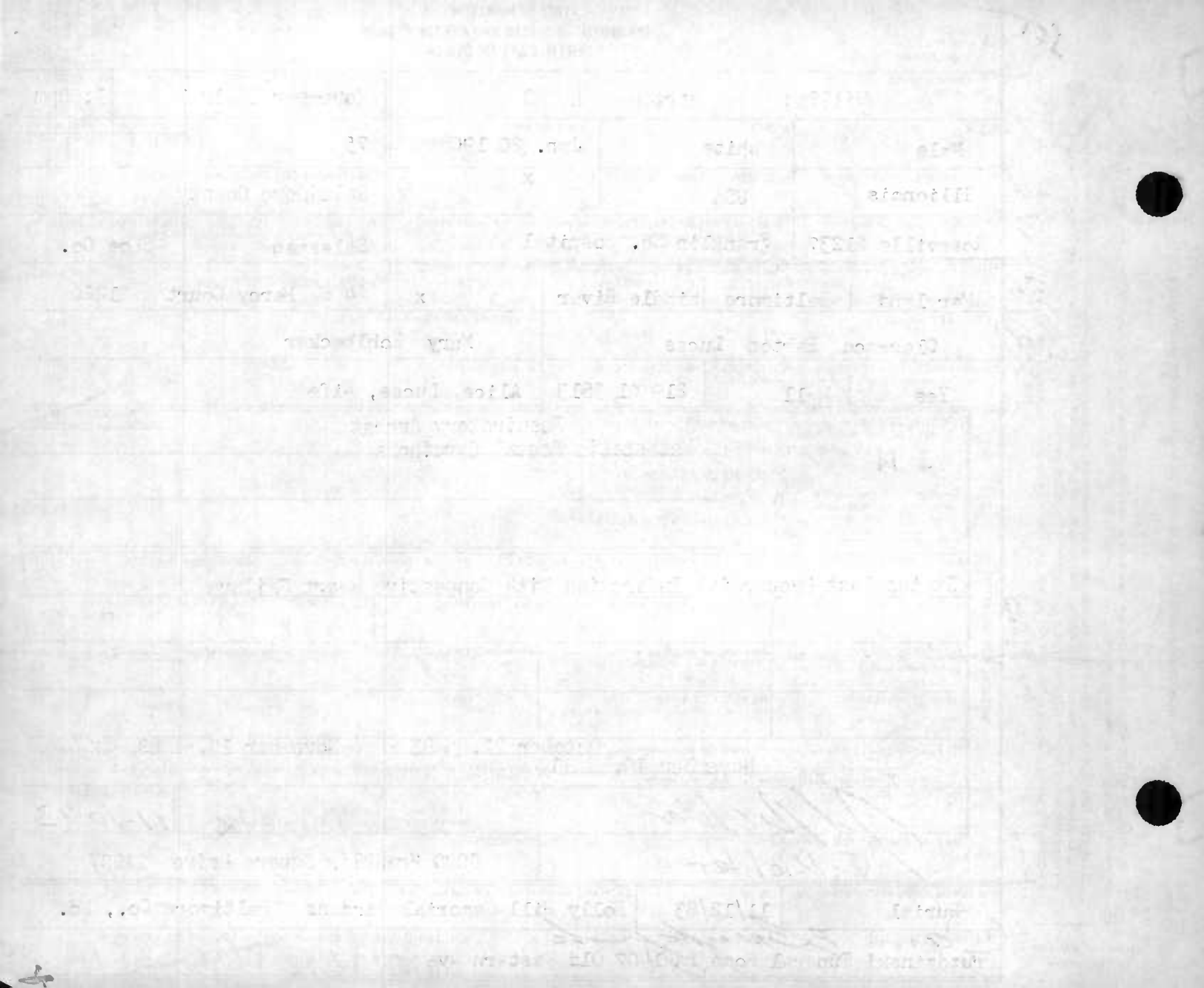
|  |  |                       |  |   |  |  |  |
|--|--|-----------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br>Burial                              |  | 23b. DATE<br>11/12/83 |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Holly Hill Memorial Gardens |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Baltimore Co., Md. |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Bruzdzinski Funeral Home PA 1407 Old Eastern Ave |  |                       |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1983                      |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Cabre                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 checks any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

|   |  |   |   |  |  |   |  |
|---|--|---|---|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Edward A LYNCH</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>November 20, 1983</b> |  | 2b. HOUR<br><b>7<sup>35</sup> A.M.</b> |   |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>Cau.</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 3 45</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>38</b> YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County, MD.</b>  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Balto.</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Franklin Square Hosp.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Security-Metro.</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Investigati</b>   |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Balto.</b>  |   | 13c. CITY OR TOWN<br><b>Balto.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jeremiah J. Lynch</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary T. Burnotes</b>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>219-42-1848</b>  |  |
| 17. INFORMANT<br><b>Mary T. Lynch</b>   |  | ADDRESS<br><b>701 Elmwood Rd. 21206</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Infarction, Acute, Posterior Left Ventricle</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>4100</b>  |  |   |   |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 12, 1983</b> to <b>November 20, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>November 20, 1983</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. |  |   |   |  |  |   |  |
| 22b. SIGNATURE<br><b>James Sides</b>  |  |   |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>11/20/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>James Sides, M.D.</b>   |  |   |   | 22e. ADDRESS<br><b>9000 Franklin Square Drive 21237</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>11-23-83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Balto. Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>John C. Miller Inc. 6415 Belair Rd.</b>  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>NOV 21 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. [Signature]</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |  |  | REG. NO.  |  |   |  |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Ellsworth C LYNN  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>November 5, 1983   |  |   |  | 2b. HOUR<br>6:10 p   |  |
| 3. SEX<br>m   |  | 4. RACE<br>W   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>4/10/10   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>MD.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Baltimore county MD.                                    |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>ROSSVILLE  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>FRANKLIN SQ. HOSP |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)                                |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TRUCKING  |  |
| 13a. STATE<br>MD  |  | 13b. COUNTY<br>BALTO.  |  | 13c. CITY OR TOWN<br>MIDDLE RIVER   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>21230 HENDERSON RD  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>MILTON C. LYNN  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNK  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>UNK   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>22005 6243  |  | 17. INFORMANT<br>BEULAH LYNN  |  |   |  | ADDRESS<br>ABOVE   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest<br>5991<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Sepsis<br>(c) Multiple perineal fistular and bilateral decubitus of the buttock<br>Diabetes |  |  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |  |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |  |  |
| 22a. I certify that (this hospital) attended the deceased from July 24, 1983, to Nov 5, 1983, that (we) lost saw the deceased alive on Nov 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |  |  |  |
| 22b. SIGNATURE<br>Robert J. Tretola M.D.  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>        |  |   |  | 22c. DATE SIGNED<br>11-5-83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Robert J. Tretola M.D.   |  |  |  | 22e. ADDRESS<br>9000 Franklin Square Dr., 21237   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |  | 23b. DATE<br>11/9/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>SECURITY PROCESS  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTO. MD   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME J.G. CONNELLY ADDRESS 300 MALE   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>NOV 14 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Connel  |  |  |  |

BP



13

4/15/12

W.

M.

1220

MD

ROSSVILLE BRANCH CO. WORK

TRUCK

NO. 2 COIN MACHINE

NO. 22 REFRIGERATOR

DELIVER TO WORK

WORK SETS AND COIN MACHINE

11.2.12

RECEIVED 11/12/12

COIN MACHINE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 28929   |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) James W. Malone   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 11-6-83   |  |  |  |
| 3. SEX Male   |  | 4. RACE Caucasian  |  | 5. DATE OF BIRTH MONTH DAY YEAR 2-14-31  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.   |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City County MD.   |  |
| 10. CITY OR TOWN OF DEATH Baltimore   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7119 Baltimore Street |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheet Metal Mechanic   |  | 12b. KIND OF BUSINESS OR INDUSTRY Kelco Co.  |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  | 13a. STREET ADDRESS / ZIP CODE 7119 Baltimore Street 21224   |  |  |  |
| 13a. STATE Md.  |  | 13b. COUNTY Balto.   |  | 13c. CITY OR TOWN Balto.   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John J. Malone  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida May Wertz   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no  |  | 16b. SOCIAL SECURITY NO. 213-28-4680   |  | 17. INFORMANT ADDRESS 21224 Patricia Malone 7119 Baltimore St.   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE STOMACH WITH METASTASIS TO THE LIVER.<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1519 |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from August 12, 1982, to November 6, 83, that (I) (we) last saw the deceased alive on Nov. 6, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |
| 22b. SIGNATURE Dr. Lydia Jumamoy  |  |  |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lyda Jumamoy  |  |  |  | 22e. ADDRESS CHURCH HOSPITAL, 100 N. BROADWAY  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 11-9-83  |  | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. 21213   |  |
| 24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213   |  |  |  | 25a. DATE REC'D. BY REGISTRAR NOV 8 1983   |  | 25b. REGISTRAR'S SIGNATURE John J. Smith   |  |

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |   |  |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>EDNA M. LYONS</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>11-30-83</b> |   |  | 2b. HOUR<br>MIN.<br><b>10:55 PM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 5, 1902</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>81</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Baltimore County MD.</b>  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Randallstown</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Baltimore County Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Balti. City</b>       |  |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Sykesville</b>  |  | 13c. CITY OR TOWN<br><b>Sykesville</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>608 KALORAMA ROAD</b>               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George Fretwell</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unk.</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>220 12 5576</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Edna Mae Easton - Sykesville, Md</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RENAL FAILURE</b><br><b>4049</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>CONGESTIVE HEART FAILURE, HYPERTENSIVE ARTERIOSCLEROTIC</b>  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CARDIOTOMY</b>   |  |   |  | 19c. ANY EYES, EARS, NOSE, OR THROAT IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 19d. YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET   |  | CITY OR TOWN   |  | COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>9-26</b> 19 <b>83</b> , to <b>11-30</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>11-30</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.      |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Orlando B. Conanan</b>   |  |   |  | DEGREE  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br><b>11-30-83</b>                           |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ORLANDO B. CONANAN, M.D.</b>  |  |   |  | 22e. ADDRESS<br><b>664 - RANDALLSTOWN MD 21133</b>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(TYPE)<br><b>Burial</b>  |  | 23b. DATE<br><b>1-5-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>McKendree Cemetery</b>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Cockeysville Howard Md.</b>   |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Harry W. Haight</b>  |  |   |  | ADDRESS<br><b>Sykesville, Md.</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>DEC 2 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canine</b>           |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



Female  
 White  
 April 2, 1952  
 Baltimore County  
 Clark  
 Baltimore County  
 George  
 Frederick  
 22012 22012 Edman, Evelyn - Sykesville, Md  
 D.K.

1-5-83  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |  |  |
|---|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>VIOLA A LYONS  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>11/13/83                        |   |  | 2b. HOUR<br>2:14 PM   |   |  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>09 20 05  |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY)<br>78 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MARYLAND   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>COUNTY TOWSON, MD.                                      |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>TOWSON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>ST JOSEPH'S HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BINDERY WORKER              |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>CASUALTY CO.  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>BALTO  |  | 13c. CITY OR TOWN<br>BALTIMORE  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>HARRY   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>MARIAN UNKNOWN   |  | 13e. STREET ADDRESS<br>2518 E JOPPA ROAD 21234  |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>212-20-7291  |  | 17. INFORMANT<br>ADDRESS<br>VERNON LYONS (HUSBAND) SAME ADDRESS   |  |   |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 RESPIRATORY-CARDIAC FAILURE.<br>DUE TO, OR AS A CONSEQUENCE OF CHRONIC OBSTRUCTIVE PUL. DISE.<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) ARTERIO-SCLEROTIC HEART DISE.<br>(c) |  |   |  |   |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |   |  |   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-6-83, 19____, to 11-13-83, 19____, that (I) (we) last saw the deceased alive on 11-13-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |   |  |  |
| 22b. SIGNATURE<br>J. H. [Signature]<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>   |  |   |  |   |  | 22c. DATE SIGNED<br>11/13/83  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>3314 E JOPPA ROAD  |  |   |  | 22e. ADDRESS<br>BALTO., MD. 21234.  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>11/16/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>PARKWOOD |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>BALTIMORE MD.  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>SCHUMNEK FUNERAL HOME, INC.<br>9705 Belair Rd., Baltimore, Md. 21236  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br>NOV 15 1983   |   | 25b. REGISTRAR'S SIGNATURE<br>[Signature] |  |  |

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A copy of this certificate may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



RECEIVED  
FEB 10 1964  
U.S. AIR FORCE

GOVERNMENT OF THE UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY  
WASHINGTON, D.C. 20315